ENCOUNTER DATA ELEMENT DICTIONARY FOR MANAGED CARE PLANS VERSION 1.5

July 2006
Payment Systems Division
Office Of Medi-Cal Payment Systems
Management Information/Decision Support System
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CURRENT AND PREVIOUS CHANGES TO THE DATA ELEMENT DICTIONARY

2006

Current changes to the Data Element Dictionary are as follows:

NO.	ITEM	PAGES	DATE
1	Current Data Element Dictionary has been updated and reformatted		July 2006
2	Medium Used For Submission of Data		July 2006
3	Edit Process		July 2006
4	No. 3 Format Code		July 2006
5	No. 17 Provider Type Code		July 2006
6	No. 18 Physician Specialty Code		July 2006
7	No. 38 Place of Service		July 2006
8	No. 39 Procedure Code (CPT-4, HCPCS, or UB-92 Codes)		July 2006
9	No. 40 Procedure Modifier		July 2006
10	No. 45 Drug/Medical Supply Quantity		July 2006
11	No. 47 Long Term Care (LTC) Accommodation Codes		July 2006
12	No. 51 Patient Status Code		July 2006
13	No. 52 Admission Necessity Code		July 2006
14	Appendix A-Standard Code Sets		July 2006
15	Appendix B-List of Abbreviations		July 2006
16	Appendix C-Removed		July 2006

Previous Changes to the Data Element Dictionary:

NO.	ITEM	NO. PAGES	DATE
1	Enclosures/Letters of Changes	Variable	October 2002
2	Table of Contents	3	April 1999
3	Medium for Submission of Data Data Transmission Options-Tape Transmission Data Transmission Options-Disk Transmission Medi-Cal Extranet for Stat Healthcare (MESH)	5	April 1999
4	Tables of Data Elements	2	January 31, 1994
5	Header Record Format	1	July 21, 1994
6	Header Record Elements Submitter ID Volume ID Media Type Header Indicator Submission Date Submitter Name Record Count Creation Date	3	December 26, 1995
7	Record Layout Managed Care Non-Inpatient Encounter Data Managed Care Inpatient Encounter Data	 3 5	 February 1995 December 1995
Managed Care Data Elements			
8	#1 Claim Reference Number (CRN)	1	December 18, 1995
9	#2 Plan Code	1	March 1997
10	#3 Format Code	1	April 1999
11	#4 Program Code	1	October 2002
12	#5 Adjustment Code	3	April 1999
13	#6 Adjustment Claim Reference Number (CRN)	1	April 1999
14	#7 Medi-Cal Beneficiary Identification (BID)	1	December 18, 1995
15	#8 Social Security Number (SSN) or Client Index Number (CIN)	1	October 2002
16	#9 Name of Medi-Cal recipient	1	December 18, 1995

(Previous Changes to the Data Element Dictionary-Continued)

NO.	ITEM	NO. PAGES	DATE
Managed Care Data Elements-Continued			
17	#10 Dirth Date of Medi-Cal Recipient	1	Decembe 18, 1995
18	#11 Sex of Medi-Cal Recipient	1	December 18, 1995
19	#12 Ethnic/Race Code Of Medi-Cal Recipient	1	December 18, 1995
20	#13 Provider Number (Reporting/Billing)	1	April 1999
21	#14 Provider Name (Reporting/Billing)	1	December 18, 1995
22	#15 Zip of Provider (Rendering)	1	December 18, 1995
23	#16 County of Provider (Rendering)	1	December 18, 1995
24	#17 Provider Type Code	2	October 2002
25	#18 Physician and Dental Specialty Codes	3	March 1997
26	#19 Beginning Date of Service	1	December 18, 1995
27	#20 Ending Date of Service	1	December 18, 1995
28	#21 Referring/Prescribing/Admitting Provider	1	April
29	#22 Prior Authorization or Primary Care Physician (PCP) Referral Indicator	1	April 1999
30	#23 Primary Diagnosis (ICD 9 CM)	1 page	October 2002
31	#24 Secondary Diagnosis (ICD 9 CM)	1 page	April 1999
32	#25 Tertiary Diagnosis (ICD 9 CM)	1 page	April 1999
33	#26 Family Planning Indicator	1 page	December 18, 1995
34	#27 Adjudication Status Code	1 page	April 1999
35	#28 Adjudication Date	1 page	October 2002
36	#29 Date of Payment by Plan (Check Date)	1 page	December 18, 1995
37	#30 Billed Amount	1 page	March 1997

(Previous Changes to the Data Element Dictionary-Continued) Managed Care			
No.	ITEM	NO. PAGES	DATE
Managed Care Data Elements-Continued			
38	#31 Reimbursement Amount	1 page	December 18, 1995
39	#32 Patient Liability Amount (Share of Cost)	1 page	March 1997
40	#33 Medicare Deductible Amount	1 page	March 1997
41	#34 Medicare Co-Insurance Amount	1 page	December 18, 1995
42	#35 Other Health Coverage Amount	1 page	March 1997
43	#36 Empty		
44	#37 Tooth Surface Locations	1 page	April 1999
45	#38 Place of Service (POS)	1 page	October 2002
46	#39 Procedure Code (CPT-4 or Dental Codes)	1 page	October 2002
47	#40 Procedure Modifier Code or Tooth	1 page	October 2002
48	#41 Medical Outpatient and Dental Procedure Quantity	1 page	March 1997
49	#42 Rendering Provider Number	1 page	April 1999
50	#43 Drugs/Medical Supplies	1 page	January 1998
51	#44 Drug/Medical Supply Indicator Code	1 page	December 20, 1995
52	#45 Drug/Medical Supply Quantity	1 page	December 18, 995
53	#46 Days Supply	1 page	December 18, 1995
54	#47Long Term Care (LTC) Accommodation Codes	3 pages	April 1999
55	#48 Days Stay	1 page	December 18, 1995
56	#49 Admission Date	1 page	December 18, 1995
	#50 Discharge Date	1 page	October 2002
	#51 Patient Status Code	2 pages	March 1997
	#52 Admission Necessity Code	1 page	March 1997
	#53 Primary Surgical Procedure Code	1 page	October 2002
	#54 Secondary Surgical Procedure Code	1 page	October 2002
	#55 Empty		
	#56 Number of Claim Lines	1 page	December 18, 1995
	#57 Accommodation and Ancillary Codes	1 page	October 2002
	Appendix A: Dental Codes Matched to HCPC Codes	13 pages	December 26, 1995
	Appendix B: Procedure Modifiers	6 pages	December 26, 1995
	Appendix C: List of Abbreviations	1 page	March 1997

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MEDIUM USED FOR SUBMISSION OF DATA

2006

MEDIUM FOR SUBMISSION OF DATA

All encounter data must be submitted through Medi-Cal Web Site telecommunication. The data must been in ASCII or EBCDIC format and in the appropriate “encounter data submission record layout”. The web site is a communications infrastructure that supports the secure exchange of electronic information among the many organizations accessing the web site. Paper submissions for encounter data are not acceptable.

When using the Medi-Cal Web Site for faster uploads, compress files using PKZIP or WINZIP. Upload file size is limited to 2 Mb during peak business hours (8:00 AM to 6:00 PM), and 6 Mb during off-peak business hours. If your input file exceeds this size, it will not be accepted by Medi-Cal.

The naming convention used when setting up the file is at the discretion of the submitter.

Before every submission, the plan must send e-mail to their assigned EDS analyst.

TRANSMISSION

Telecommunication: Medi-Cal Web Site

ACCESSING THE MEDI-CAL WEB SITE

To sign up for a Medi-Cal Web site User ID and Password you must fill out the Medi-Cal Web Site Managed Care Plan Agreement Form. Please contact the POS Help Desk for the Medi-Cal Web Site Managed Care Plan Agreement Form.

POS/Internet Help Desk
PO Box 13029
Sacramento, CA 95813
1-800-427-1295

(See sample document at end of this section). ***This form is available on the web site*.**

To access the Medi-Cal Web site, you will need Internet access, a computer with the monitor screen resolution set to 1024 x 768 dots per inch (DPI) and a Web browser.

Recommended browsers include the latest versions of Microsoft® Internet Explorer or Netscape® Navigator, both of which can be downloaded, free, from

the World Wide Web. Refer to the "Downloading Free Web Tools with the Web Tool box" section for links to browser download sites.

Configuring a Web Browser

After downloading a browser, ensure that your browser interprets JavaScript and accepts cookies. Please see below for setup instructions. This step is completed differently for Microsoft® Internet Explorer and Netscape® Navigator.

Microsoft® Internet Explorer (Version 5.0)

Choose "Tools" from the menu bar at the top.

Click on "Internet Options" under the "Tools" menu. The "Internet Options" dialog box displays.

Click on the "Advanced" tab in the "Internet Options" box. The "Advanced" screen displays.

In the "Advanced" screen, scroll to "Java JIT compiler enabled" then click in the box. A check displays in the box.

When a check displays in the box, click on the "OK" button. The settings are recorded by the browser.

Netscape® Navigator (Version 4.0)

Choose "Edit" from the menu bar at the top. The "Edit" menu displays. In the "Edit" menu, click on "Preferences." The "Preferences" window displays.

In the "Category" box of the "Preferences" window, click on the "Advanced" category. The "Advanced" screen displays to the right of the "Category" box.

In the "Advanced" screen, click in the boxes that say "Enable Java," "Enable JavaScript" and "Accept all cookies." A check displays in each box.

When done, click the "OK" button. The browser window displays.

To access the Medi-Cal Web site, type in the following address in the address box of your browser: www.medi-cal.ca.gov. The Medi-Cal homepage displays. Clicking on the links on the homepage enables you to use the products and services available on the Web site.

SAMPLE MEDI-CAL WEB SITE MANAGED CARE PLAN AGREEMENT FORM

This agreement is required of all Medi-Cal Managed Care Plans (Plan) intending to utilize the Medi-Cal Web Site applications at www.medi-cal.ca.gov.

I (a). The California Department of Health Services (DHS) will permit the use of the California Medi-Cal Web Site by the following Managed Care Plan:

Plan Name: _____ subject to the terms and conditions of this agreement.

I (b). Plan requests access to the Medi-Cal Web Site for the following service(s) and are subject to the terms and conditions of this agreement:

_____ 1). Encounter Data
_____ 2). Eligibility File (FAME)
_____ 3). RAF File (For Placer and Sonoma Counties Only)

II. Plan agrees to limit the usage of the Medi-Cal Web Site to the following Medi-Cal eligibility and claims-related transactions on the Medi-Cal Web Site:

A. Submission of other transactions as may be subsequently permitted by DHS and as documented in one or more of the user manuals identified above or in the Publications area of the Medi-Cal Web Site.
B. Browsing of Medi-Cal Web Site.
C. Submission and retrieval of Encounter Data files and/or reports.
D. Retrieval of the Eligibility file (FAME), and RAF files

III. Plan agrees to report all malfunctions of the Medi-Cal Web Site to EDS' POS/Internet Help Desk at 1-800-427-1295.

IV. Plan acknowledges that failure to limit the usage of the Medi-Cal Web Site to the transactions and or processes described above may, at a minimum, result in DHS revoking the privilege to use the Medi-Cal Web Site. Abuse of transactions and processes available on the Medi-Cal Web Site may result in DHS revoking Plan access to the Medi-Cal Internet.

V. Plan acknowledges that neither DHS nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHS.

VI. For POS Help-Desk validation, Plan contact validation data:

Primary Name:_____ Phone:_____ Email:_____

Back-up Name:_____ Phone:_____ Email:_____

Plan Validation Password:

VII. Plan Signature:

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement. Phone number is provided in the event both the Primary or Back-up is not the caller requesting help from the POS Help Desk. The Authorized Signatory will be contacted to confirm caller's identification.

Printed Name of Signatory	Authorized Signature	
Title	Phone	Date

For assistance or inquiries please call the POS/Internet Help Desk at 1-800-427-1295 between the hours of 6:00 AM and 12:00 AM, Sunday through Saturday.

Return the completed and signed agreement to:

POS/Internet Help Desk
PO Box 13029
Sacramento, CA 95813
1-800-427-1295

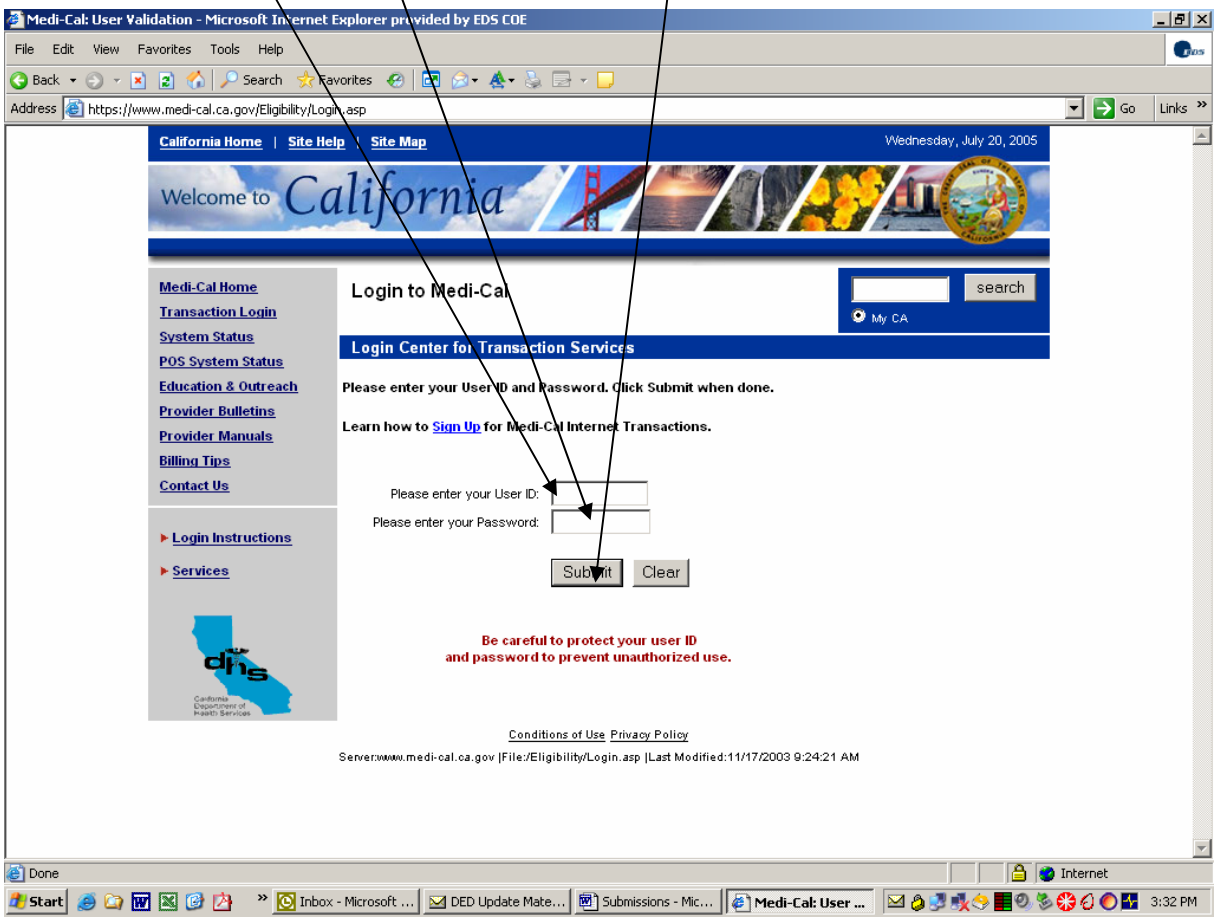
The user will view the following screen when logging into the Medi-Cal Web site.

1. Medi-Cal Home Page

Action: Click on Transaction Services.

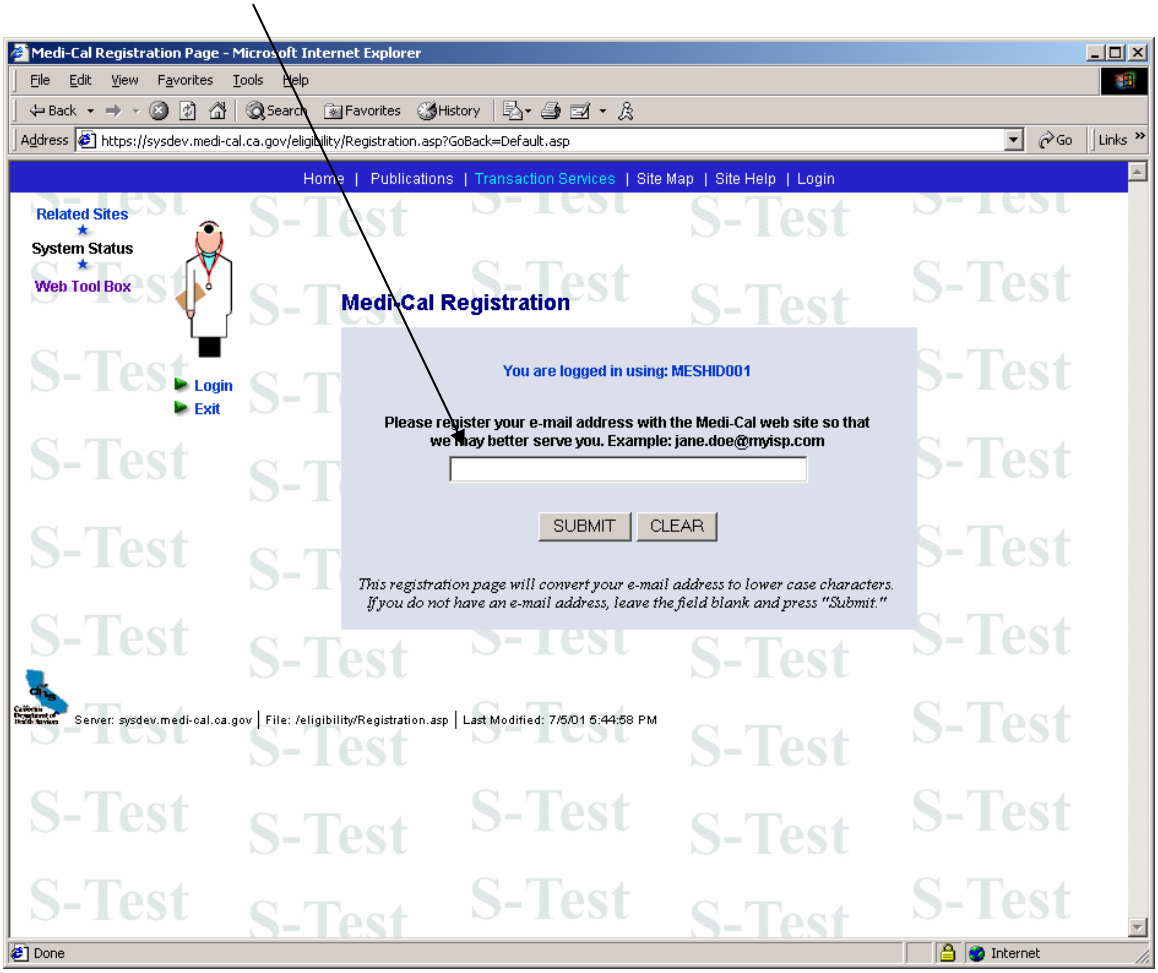
2. User Validation-login

Action: Enter User ID and Password and press SUBMIT.



3. Medi-Cal Registration Page

Action: Enter email address (optional).

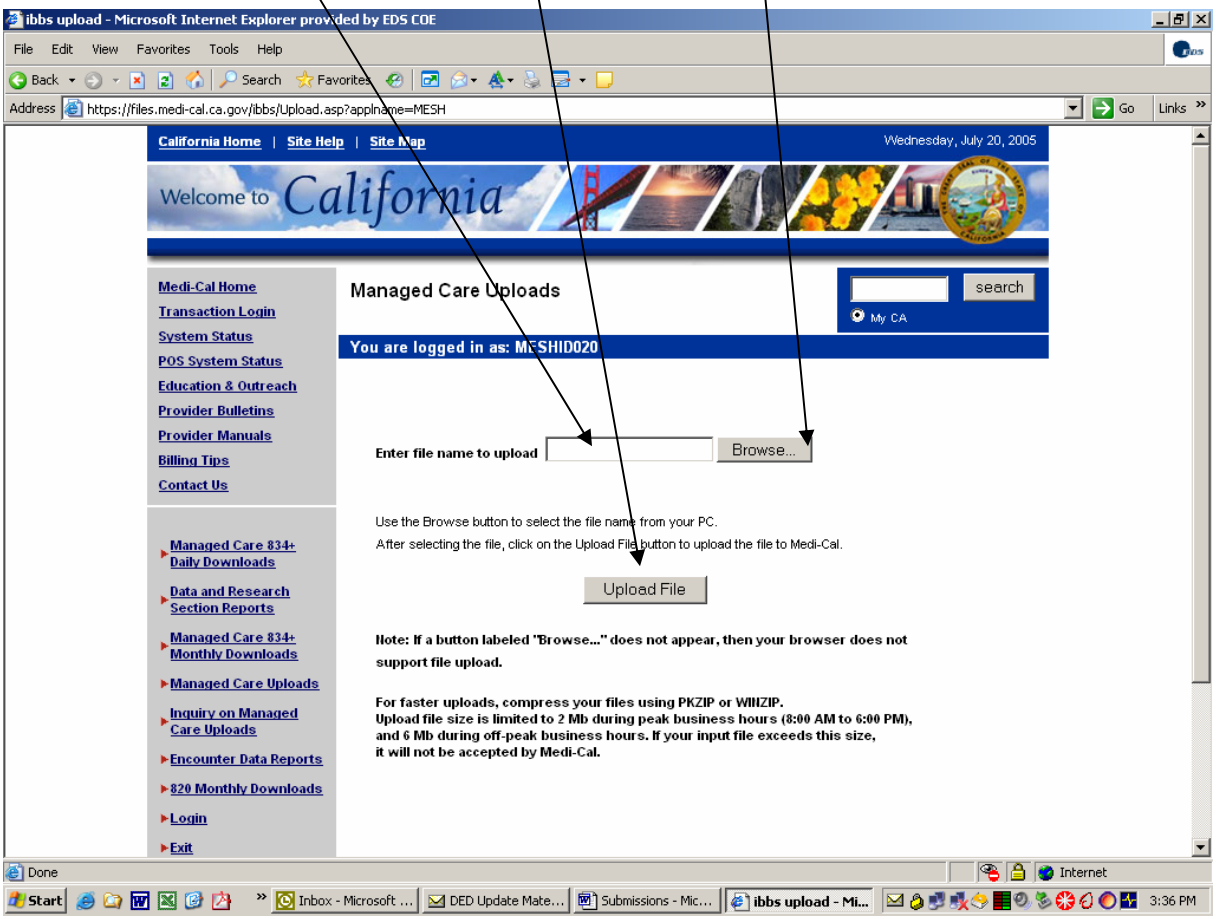


4. Provider Services Main Menu

Action: Click on Managed Care Uploads.

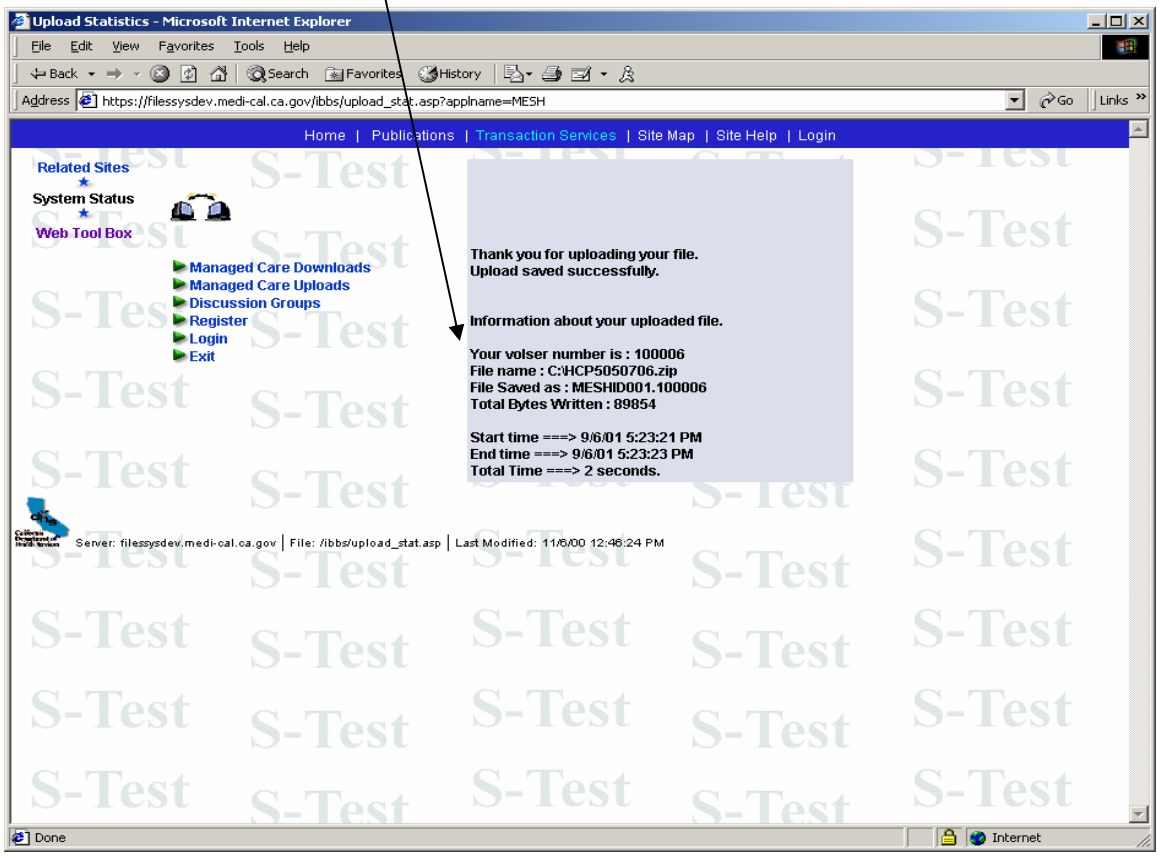
5. Managed Care Uploads

Action: Hit Browse, select a file and press Upload File.



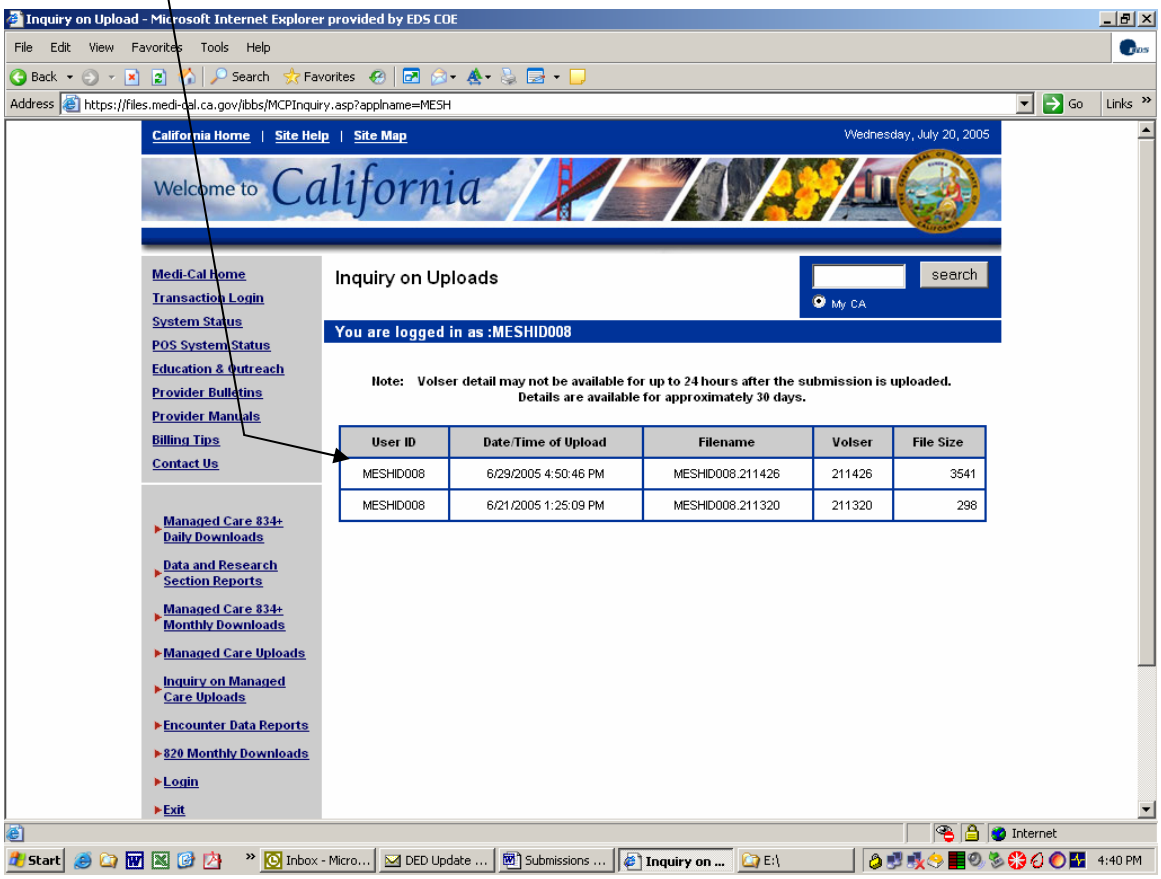
6. Managed Care Upload Response

Action: User writes down Volser number for future reference.



7. Inquiry Managed Care Downloads

Action: This is a listing of all files successfully uploaded.



EDIT PROCESS

2006

Test Condition Description	Test Condition Description
DE 01: **Claim Reference Number** 1. CRN is duplicate of another record within same file. 2. CRN date is greater or less than the run date. 3. CRN contains less than 13 numeric characters, contains invalid characters or is in an invalid format.	**DE 08: SSN –** 1. Record contains a Medi-Cal BID, CIN (Client index number) or SSN (Social Security number) that are not found on the Eligibility file. 2. Record contains an ID with invalid characters (spaces or special character).
DE 02: **Plan Code** 1. File contains a plan code in the header record that does not match the code in the body of the record. 2. Record contains invalid characters or is in an invalid format.	3. Record contains a SSN that has alphanumeric characters in bytes 2 through 8.
DE 03: **Format Code** 1. Format code on record is not an M, P, L or H or is left blank.	**DE 09**: **Beneficiary Name** 1. Record contains spaces for the beneficiary name.
DE 04: **Program Code** 1. Program code on record is not a C, S or P or is left blank.	**DE 10: Date of Birth** 1. Record contains a DOB that is not numeric or is not in a valid format. 2. Record contains DOB that is greater than the run date. 3. Record contains a DOB with the year less than 1850 or greater than 2050
DE 05: **Adjustment Code** 1. Record is left blank and an adjustment CRN, DE #6 is present. 2. Record contains a code and no adjustment CRN is present	**DE 11**: **Sex Code (#1 is informational only)** 1. Record contains a blank or is not 'M' or 'F'
DE 06: **Adjustment CRN** 1. CRN contains less than 13 numeric characters, contains invalid characters or is in an invalid format.	**DE 13: Provider Number** 1. Record contains spaces or a non-alphanumeric value 2. Record contains a Billing Provider number that does not exist on the Billing Provider file (MR-F-177).
DE 07: **Beneficiary ID** 1. Record contains an invalid County code or Aid Code. Aid code must be one used in MCP. 2. Record contains a BID number that is less than 14 alphanumeric characters.	**DE 14: Provider Name** 1. Record contains spaces for the provider name
	DE 15: Zip Code 1. Record contains a nonnumeric zip code or '00000'.

Test Condition Description	Test Condition Description
DE 16: Provider County 1. Record contains a nonnumeric character or is left blank. 2. Record contains a County Code for Provider (Rendering) and the record does not exist on MMIS table 0211	**DE 21: Refer/Pres/Admit Provider #** 1. Record is a pharmacy or Inpatient record and the Referring Provider number contains spaces – This is required on all records 2. Record contains a Referring Provider number that does not exist in the Referring Provider file (MR-F-178). 3. Record contains a Referring Provider number that is not alphanumeric.
DE 17: Provider Type 1. Record contains invalid characters (not alphanumeric) for the provider type. 2. Record contains an invalid provider type (not found on Encounter table).	
DE 18: Provider Specialty 1. Field was left blank. Physician Specialty is required for Provider Types 022, 026 or DN. 2. Field contains a code. PT not 022,026 or DN. Field must be blank or filled with spaces (**informational only)**	**DE 22: Prior Authorization** No critical errors for this data element
DE 19: Beginning Date of Service 1. Record contains a date that was not numeric or in the correct format 20040925. 2. Record contains a beginning DOS that is less than the Encounter Data start (Before January 1, 1994). 3. Record contains a beginning DOS that is greater than the run date. **DE 20: Ending Date of Service** 1. Record contains a date that was not numeric or in the correct format 20040925.	**DE 23, 24 & 25: Primary/Secondary/Tertiary Diagnosis Code: Primary Dx required on all LTC & Hospital and for Provider Type (DE #17) 5,6,7,10,22,26,27,31,32,34,35,40,41,43,44, 46 or 49 in Medical Records.** 1. Diagnosis is not 5 alphanumeric characters 2. Record contains a code that does not exist on the Diagnosis file and the Encounter Data Table 3. Record is blank or contains spaces and file type requires reporting. **This pertains only to DE #23**
2. Record contains an ending DOS that is greater than the run date.	**DE 26: Family Planning Indicator** No critical errors for this data element.
3. Record contains an ending DOS that is less than the Encounter Data start (Before January 1, 1994). 4. Record contains an ending DOS that is less than beginning DOS.	**DE 27: Adjudication Status** 1. Record does not contain a C (Capitated), D (Denied) or P (Paid)
DE 28: Adjudication Date 1. Record contains a date that was not numeric or in the correct format (20040925). 2. Record contains a date that is greater than the run date. 3. Adjudication date is out of range (1994-2050)	**DE 34: – Medicare Co-ins (this field must be zero field)** 1. Field does not contain zeros

Test Condition Description	Test Condition Description
	DE 38: Place of Service 1. POS is not 2 alphanumeric characters, contains spaces or invalid characters. 2. Record contains a POS that does not exist
DE 29 – Date of Payment 1. Record contains a date that is not numeric or in the correct format (20040925) 2. Date of Payment is out of rage (1994-2050) 3. Record contains a date that is greater than the run date.	. **DE 39: Procedure Code** 1. Code is not 5 alphanumeric characters or contains invalid characters. 2. Record contains a code that does not exist on the Procedure code extract or the Encounter 1500 table.
DE 30: Billed Amount (required for Paid services only) 1. Amount is not 9 numeric characters.	. **DE 40: Procedure Modifier** 1. Code is not 2 alphanumeric characters or contains invalid characters. 2. Record contains a code that does not exist on the MMIS 0384 table or the Encounter 1200 table.
DE 31: – Reimbursement Amount (required for Paid services only) 1. Amount is not 9 numeric characters	. **DE 41: Quantity** 1. Code is not 5 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Quantity must be greater than zero.
DE 32: – Patient Liability (required only if recipient has Share of cost) 1. Amount is not 9 numeric characters	**DE 42: Rendering Provider Number - required for Provider type (DE #17) 05, 07, 10, 22 & 26** 1. Record contains spaces. 2. Field is not 12 alphanumeric characters or contains invalid characters.
DE 33: – Medicare Deductible Amount (required only if recipient has Share of cost) 1. Amount is not 9 numeric characters	**DE 43: NDC/UPC code** 1. Record is not 11 numeric characters 2. Record contains a UPC/NDC code that exists on the Formulary file.
DE 44: Drug/Medical Supply indicator (1 byte) 1. Record contains a non-alphanumeric character.	**DE 51: Discharge/Patient Status (required on LTC & Hospital or Provider type 05, 06, 10, 22 & 26 in Medical** 1. Record contains spaces/blanks and met above requirements. 2. Status is not 2 numeric characters on LTC or Hospital record 3. Status is not 2 alpha characters on Medical record
DE 45: Drug Quantity 1. Code is not 5 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Quantity must be greater than zero.	

Test Condition Description	Test Condition Description
DE 46: Days Supply 1. Code is not 3 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Quantity must be greater than zero.	**DE 52: Admission Necessity – Hospital files** 1. Record does not contain a 1 (Emergency), 2 (Elective) or 3 (Newborn) or contains spaces or invalid characters.
DE 47: LTC Accommodation Code 1. Code is not 2 alpha numeric characters or contains invalid characters. 2. Record contains an LTC accommodation code is not found on Medi-Cal MMIS table	**DE 53: 1st Surgical Code – Hospital files** 1. Code is not 5 alphanumeric characters 2. Code does not exist on the Procedure extract file.
DE 48: Days Stay 1. Code is not 3 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Days Stay must be greater than zero.	**DE 54: 2nd Surgical Code – Hospital Files** 1. Code is not 5 alphanumeric characters 2. Code that does not exist on the Procedure extract file.
DE 49: Admission Date 1. Record contains a date that was not numeric or in the correct format (20040925). 2. Admission date is out of range (1994-2050)"	**DE 56: # of Claim Lines – required on Hospital** **Files. Can submit up to 22 detail lines** 1. Code is not 2 alphanumeric characters 2. Record contains zeros or a number greater than 22.
DE 50: Discharge Date 1. Record contains a date that was not 8 numeric characters or in the correct format (20040925). 2. Discharge date is out of range (1994-2050) 3. Discharge date is before admission date (DE #49)	**DE 57: Accommodation/Ancillary codes** 1. Code is not 3 alphanumeric characters 2. Code not found on Encounter Table.
Header Record: Error in header record will reject the 'entire' file. 1. Header record count not numeric 2. Header record count not equal to actual record count in file. 3. Header record without any submitter records Encounter file contains no header record. 4. Header create date not numeric	

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ENCOUNTER DATA

HEADER RECORD

FORMAT

HEADER RECORD: SUBMITTER ID

Purpose:

Unique number to identify each plan submitter.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	3
FORMAT;	XXX
RECORD LOCATION:	Columns 1 through 3
REQUIRED ON:	Header record of each submission

COMMENTS:

DHS currently assigned each health plan a unique submitter ID that corresponds to the last three bytes of their Plan Code. Health plans must enter their unique submitter ID on the encounter header for each submission.

HEADER RECORD: VOLUME ID

Purpose:

Used by EDS to uniquely identify each submission. Leave blank.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	5
FORMAT;	XXXXX
RECORD LOCATION:	Columns 4 through 9
REQUIRED ON:	Header record of each submission

COMMENTS:

EDS USE ONLY; Leave blank.

HEADER RECORD: MEDIA TYPE

Purpose:

Identifies the media type (diskette, tape, or telecommunications) of each submission.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Columns 10
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the code corresponding to the type of media for the submission.

D= Diskette
T= Tape
E= Telecommunications

HEADER RECORD: HEADER INDICATOR

Purpose:

To identify to the processing system that this is the encounter header record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha
NUMBER OF BYTES(S) :	3
FORMAT;	XXX
RECORD LOCATION:	Columns 11 through 13
REQUIRED ON:	Header record of each submission

COMMENTS:

Enter the value of 'HDR' in this field.

HEADER RECORD: SUBMISSION DATE

Purpose:

Identifies the date the submission was sent to DHS in year and Julian date format.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric

NUMBER OF BYTES(S) :	4
FORMAT;	YJJJ
RECORD LOCATION:	Columns 15 through 18
REQUIRED ON:	Header record of each submission

COMMENTS:

Enter the last digit of the year in column 15 and the Julian date in columns 16 through 18. For example: If the submission is sent on December 15, 1995, the date in this field will be entered as '5349'.

HEADER RECORD: SUBMITTER NAME

Purpose:

Identifies the name of the health plan submitting data.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	33
FORMAT;	X(33)
RECORD LOCATION:	Columns 24 through 56
REQUIRED ON:	Header record of each submission

COMMENTS:

Enter the full name of the health plan in all UPPERCASE letters.
Left justify, space fill.

HEADER RECORD: RECORD COUNT

Purpose:

Delineates the number of records within the submission. This count should only include the number of actual data or encounter service records and should not include the header record as part of the count.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	6
FORMAT;	XXXXXX
RECORD LOCATION:	Columns 57 through 62
REQUIRED ON:	Header record of each submission

COMMENTS:

Enter the total number of encounter records (not including the header record). Right justify, zero fill. Please do not use special characters such as commas, periods, etc.

HEADER RECORD: CREATION DATE

Purpose:

Identifies the date the encounter submission media was produced by the health plan.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	6
FORMAT;	MMDDYY
RECORD LOCATION:	Columns 75 through 80
REQUIRED ON:	Header record of each submission

COMMENTS:

Enter the date the submission was created in month, day, year format. Do not use special characters such as dashes or slashes.

PLEASE NOTE: The encounter header record must be 200 bytes in length. All columns not indicated in this section with specific header data elements are filler.

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RECORD LAYOUT

2006

AGE: 1 OF 3
ATE: 07/19/2000
EVISION:
EVIEWER:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D   L A Y O U T

FILE NAME: MANAGED CARE NON-INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS

Positions 001–050

CLAIM REFERENCE NUMBER (CRN)						ADJUSTMENT CRN		BENEFICIARY ID					
JULIAN DATE (YDDD)	CLAIM NUMBER	PLAN CODE	FORMAT CODE	PROGRAM	ADJUSTMENT	JULIAN DATE (YDDD)	CLAIM NUMBER	COUNTY	AID CODE	CASE NUMBER	FBU	PER-SON	RECIP SSN
										9/H	SSN		

Positions 051–100

RECIPIENT SSN (CONT)	RECIPIENT NAME (LAST, FIRST)	BIRTHDATE				SEX	ETHNIC/RACE	PROVIDER NUMBER, LICENSE NUMBER, OR FACILITY NUMBER	PROVIDER NAME (LAST, FIRST)
		CC	YY	MM	DD				

Positions 101–150

PROVIDER NAME (CONT)	PROVIDER ZIP	PROVIDER COUNTY	PROVIDER TYPE	PHYSICIAN SPECIALTY	BEGINNING DATE OF SERVICE				ENDING DATE OF SERVICE				REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER
					CC	YY	MM	DD	CC	YY	MM	DD	

Positions 151–200

REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER (CONT)	PRIOR AUTH/	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS	FP ALMAINLYINB	FILLER	ADJUDICATION STATUS	ADJUDICATION DATE				DATE OF PAYMENT				BILLED AMOUNT	
								CC	YY	MM	DD	CC	YY	MM	DD	$$$$$$$	¢¢

MODE: BINARY - B PACKED - P
LABELS: STANDARD [X] NON-STANDARD [ ]
RECORD FORMAT: FIXED - F [ ] VARIABLE-V [X]
RECORD LENGTH: 335
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=
PROGRAMS THAT USE THIS AS: INPUT
OUTPUT MANAGED CARE PLANS

(HD.PAIDCLM.RECORD.LAYOUT(MCNONIP))

PAGE: 2 OF 3
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REVIEWER: ____________

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D   L A Y O U T

FILE NAME: MANAGED CARE NON-INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT: ____________
SOURCE: MANAGED CARE PLANS

Positions	Field	Format
201–209	REIMBURSEMENT AMOUNT	####### ¢¢
210–218	PATIENT LIABILITY AMOUNT	####### ¢¢
219–227	MEDICARE DEDUCTIBLE AMOUNT	####### ¢¢
228–236	MEDICARE COINSURANCE AMT	####### ¢¢
237–245	OTHER HEALTH COVERAGE AMT	####### ¢¢
246–248	PROVIDER TYPE (NEW IN JULY 2000)	
249–250	FILLER	

Positions	Field
251–256	FILLER
257–260	TOOTH SURFACE
261	FILLER
262–300	FILLER RESERVED FOR STATE USE

OUTPATIENT, MEDICAL, VISION OR DENTAL CLAIM DATA

Positions	Field
301–302	PLACE OF SERVICE
303–307	PROCEDURE CODE
308–309	PROCEDURE MODIFIER OR TOOTH
310–314	PROCEDURE QUANTITY
315–326	RENDERING PROVIDER NUMBER
327–328	PATIENT STATUS
329–335	FILLER

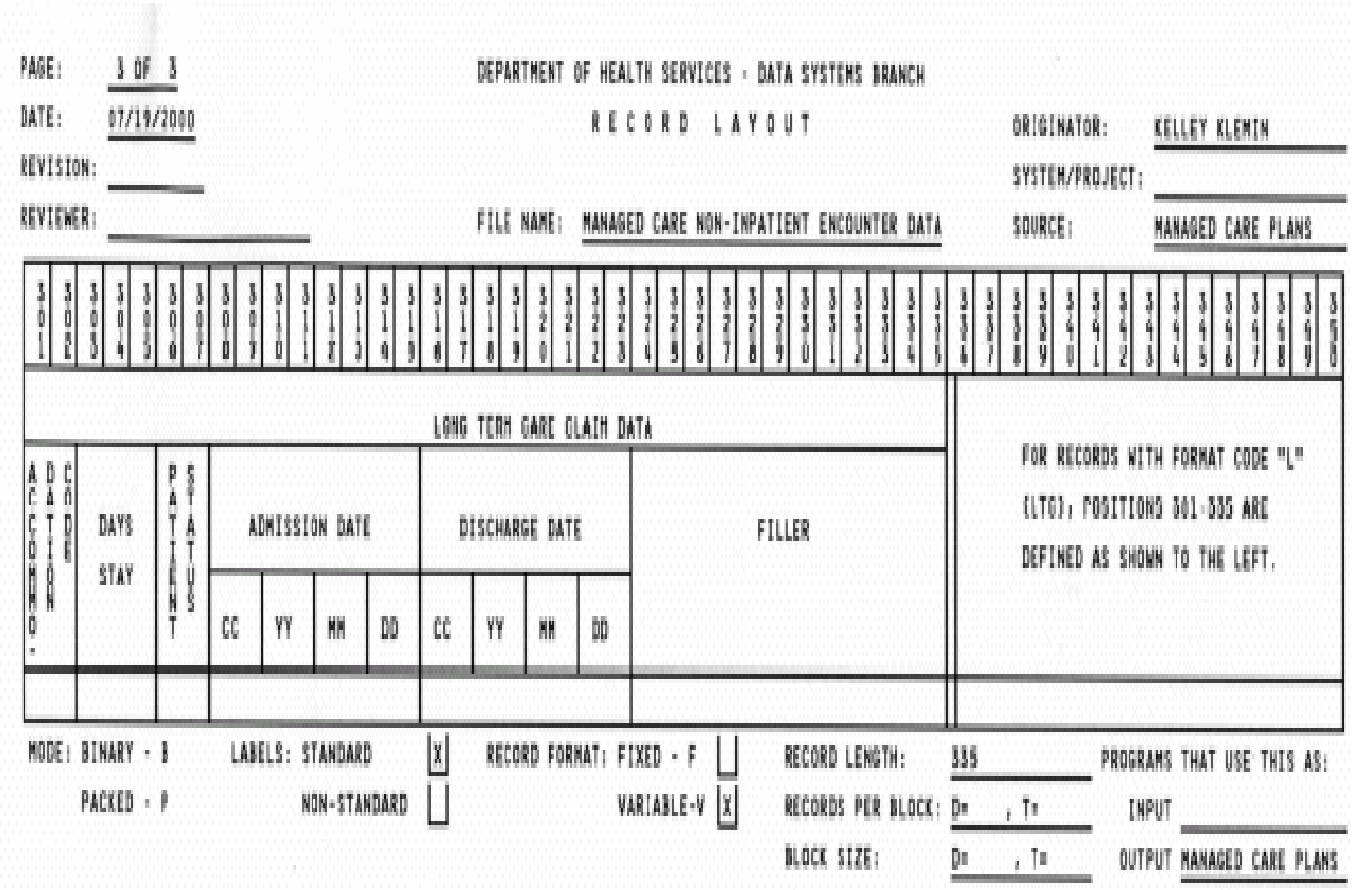
FOR RECORDS WITH FORMAT CODE "M" (OUTPATIENT, MEDICAL, VISION) OR "D" (DENTAL), POSITIONS 301-335 ARE DEFINED AS SHOWN TO THE LEFT.

DRUG CLAIM DATA

Positions	Field
301–311	NATIONAL DRUG CODE (NDC) OR UNIVERSAL PRODUCT CODE (UPC)
312	DS [illegible]
313–317	QUANTITY
318–320	DAYS SUPPLY
321–322	PLACE OF SERVICE
323–335	FILLER

FOR RECORDS WITH FORMAT CODE "P" (PHARMACY), POSITIONS 301-335 ARE DEFINED AS SHOWN TO THE LEFT.

MODE. BINARY - B / PACKED - P
LABELS. STANDARD [X] / NON-STANDARD [ ]
RECORD FORMAT: FIXED - F [ ] / VARIABLE-V [X]
RECORD LENGTH: 335
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=
PROGRAMS THAT USE THIS AS: INPUT ____________ OUTPUT MANAGED CARE PLANS


PAGE: 3 OF 3
DATE: 07/19/2000
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REVIEWER:
DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT
FILE NAME: MANAGED CARE NON-INPATIENT ENCOUNTER DATA
ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS
001 002 003 004 005 006 007 008 009 010 011 012 013 014 015 016 017 018 019 020 021 022 023 024 025 026 027 028 029 030 031 032 033 034 035 036 037 038 039 040 041 042 043 044 045 046 047 048 049 050
LONG TERM CARE CLAIM DATA
ACTION CODE
DATA CODE
DAYS STAY
PATIENT STATUS
ADMISSION DATE
CC YY MM DD
DISCHARGE DATE
CC YY MM DD
FILLER
FOR RECORDS WITH FORMAT CODE "L" (LTC); POSITIONS 001-335 ARE DEFINED AS SHOWN TO THE LEFT.
MODE: BINARY - B
PACKED - P
LABELS: STANDARD X
NON-STANDARD
RECORD FORMAT: FIXED - F
VARIABLE-V X
RECORD LENGTH: 335
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=
PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS

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DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT
FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS

001-012	013-018	019	020	021	022-029	030-034	035-036	037-038	039-048	049-050
CLAIM REFERENCE NUMBER (CRN)					ADJUSTMENT CRN		BENEFICIARY ID			
JULIAN DATE (YDDD)	CLAIM NUMBER	PLAN CODE	PRIMARY CODE	PROGRAM	JULIAN DATE (YDDD)	CLAIM NUMBER	COUNTY	AID CODE	CASE NUMBER / 9/M SSN / PERSON	RECIP SSN

051-056	057-066	067-068	069-072	073-074	075-076	077-078	079-098	099-100
RECIPIENT SSN (CONT)	RECIPIENT NAME (LAST, FIRST)	BIRTHDATE CC	BIRTHDATE YY	BIRTHDATE MM	BIRTHDATE DD	SEX / ETHNIC/RACE	PROVIDER NUMBER, LICENSE NUMBER, OR FACILITY NUMBER	PROVIDER NAME (LAST, FIRST)

101-117	118-121	122	123	124	125	126	127	128-130	131-134	135-138	139-142	143-146	147-150
PROVIDER NAME (CONT)	PROVIDER ZIP	PROVIDER TYPE	PROVIDER COUNTY	PROVIDER NUMBER	PROVIDER TYPE	PHYSICIAN SPECIALITY	BEGINNING DATE OF SERVICE CC	BEGINNING DATE OF SERVICE YY	BEGINNING DATE OF SERVICE MM	BEGINNING DATE OF SERVICE DD	ENDING DATE OF SERVICE CC	ENDING DATE OF SERVICE YY	ENDING DATE OF SERVICE MM	ENDING DATE OF SERVICE DD	REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER

151-166	167	168-187	188-207	208-227	228	229	230	231-234	235-238	239-242	243-246	247-252	253-254
REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER (CONT)	PRIOR AUTH/ REFERRAL	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS	FAMILY PLANNING	FILLER	ADJUDICATED AS-IS	ADJUDICATION DATE CC	ADJUDICATION DATE YY	ADJUDICATION DATE MM	ADJUDICATION DATE DD	DATE OF PAYMENT CC/YY/MM/DD	BILLED AMOUNT ******.**

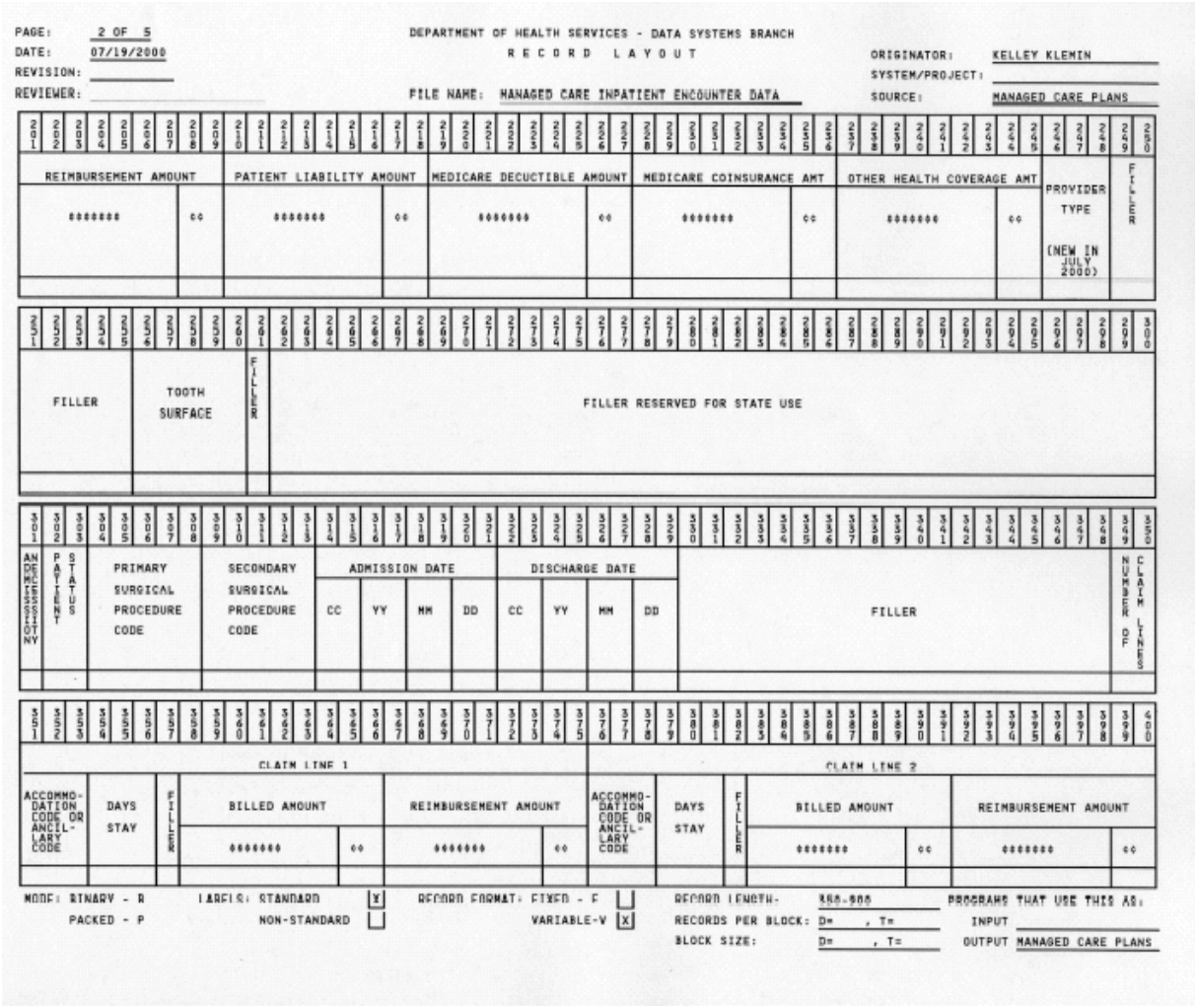
MODE: BINARY - B
PACKED - P
(HD.PAIDCLM.RECORD.LAYOUT(MCIP))

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [ ]
VARIABLE-V [X]

RECORD LENGTH. 350-900
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS



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REVIEWER:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS

FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

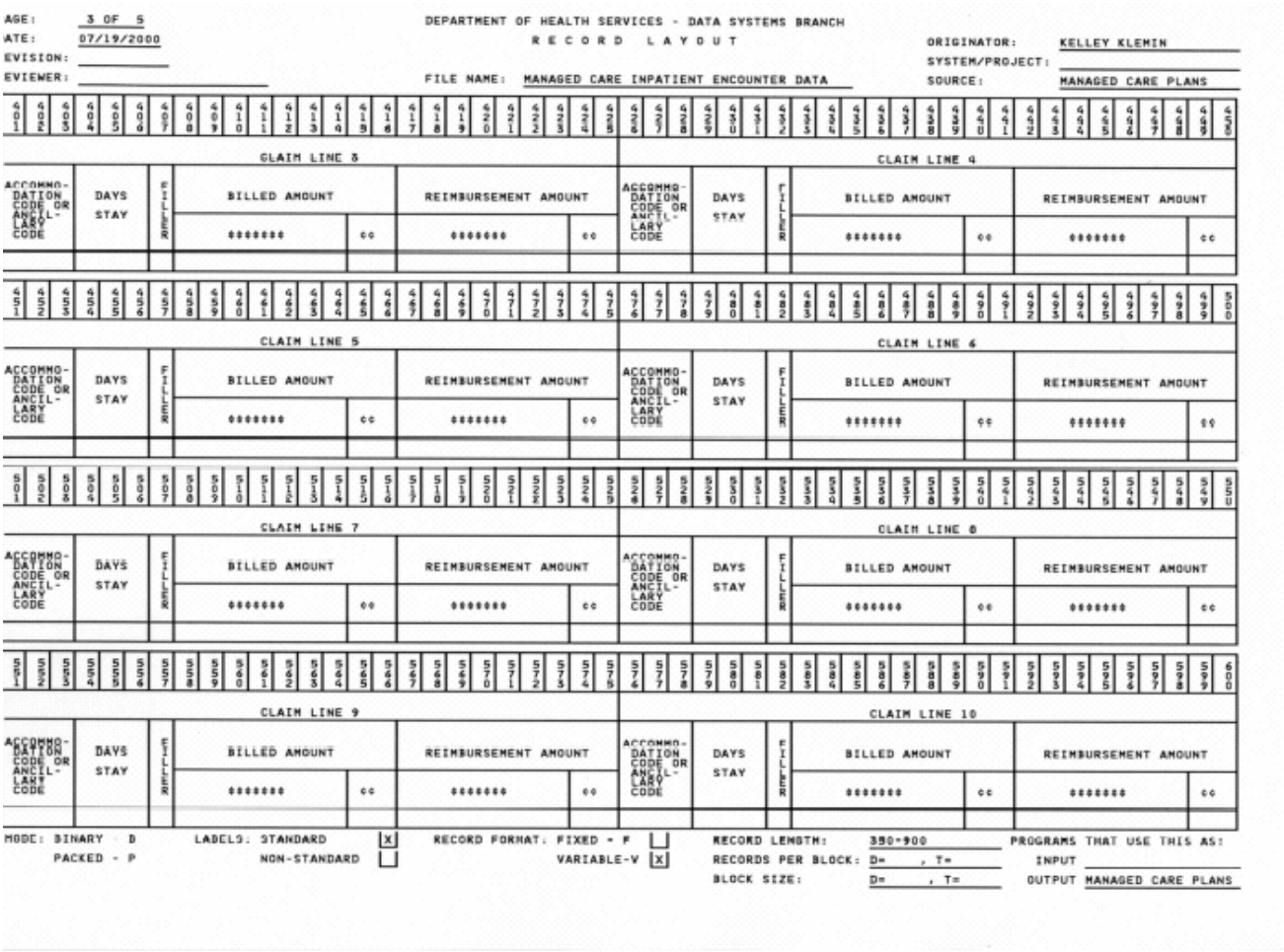
REIMBURSEMENT AMOUNT		PATIENT LIABILITY AMOUNT		MEDICARE DEDUCTIBLE AMOUNT		MEDICARE COINSURANCE AMT		OTHER HEALTH COVERAGE AMT		PROVIDER TYPE (NEW IN JULY 2000)	FILLER
$$$$$$$	¢¢	$$$$$$$	¢¢	$$$$$$$	¢¢	$$$$$$$	¢¢	$$$$$$$	¢¢		

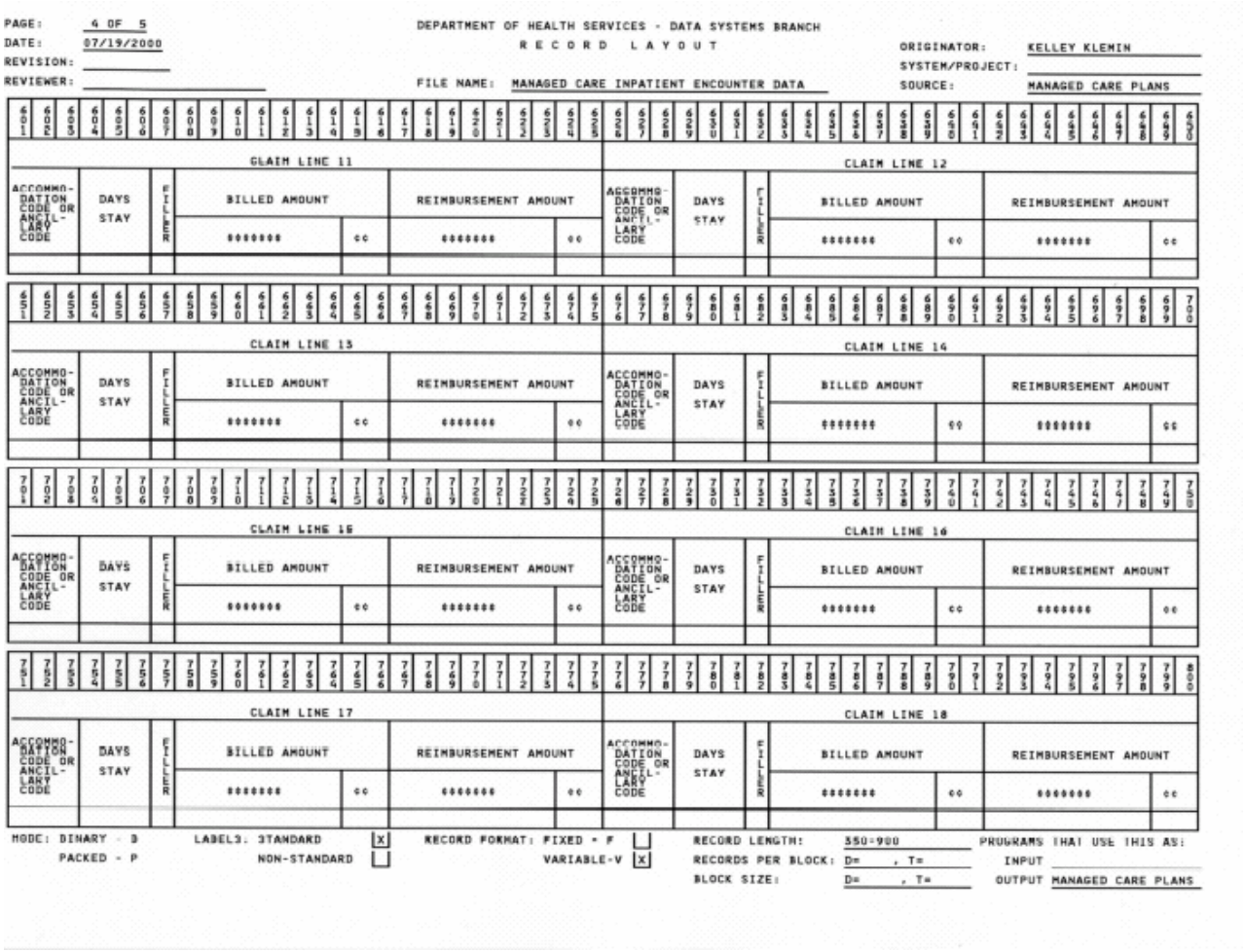
FILLER	TOOTH SURFACE	FILLER	FILLER RESERVED FOR STATE USE

ANCILLARY SERVICE INDICATOR	PATIENT STATUS	PRIMARY SURGICAL PROCEDURE CODE	SECONDARY SURGICAL PROCEDURE CODE	ADMISSION DATE				DISCHARGE DATE				FILLER	NUMBER OF CLAIM LINES
				CC	YY	MM	DD	CC	YY	MM	DD		

CLAIM LINE 1						CLAIM LINE 2					
ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			$$$$$$$	¢¢	$$$$$$$	¢¢				$$$$$$$	¢¢	$$$$$$$	¢¢

MODE: BINARY - B [ ] PACKED - P [ ]
LABELS: STANDARD [X] NON-STANDARD [ ]
RECORD FORMAT: FIXED - F [ ] VARIABLE-V [X]
RECORD LENGTH: 186-986
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=
PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS


AGE: 3 OF 5
ATE: 07/19/2000
EVISION:
EVIEWER:
DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT
FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA
ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS
CLAIM LINE 3
CLAIM LINE 4
CLAIM LINE 5
CLAIM LINE 6
CLAIM LINE 7
CLAIM LINE 8
CLAIM LINE 9
CLAIM LINE 10
ACCOMMO-DATION CODE OR ANCIL-LARY CODE
DAYS STAY
FILLER
BILLED AMOUNT
REIMBURSEMENT AMOUNT
$$$$$$$
CC
MODE: BINARY - B
PACKED - P
LABELS: STANDARD [X]
NON-STANDARD [ ]
RECORD FORMAT: FIXED - F [ ]
VARIABLE-V [X]
RECORD LENGTH: 350-900
RECORDS PER BLOCK: B= , T=
BLOCK SIZE: B= , T=
PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS



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DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT
FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS

CLAIM LINE 11					CLAIM LINE 12				
ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT	ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT
			******* cc	******* cc				******* cc	******* cc

CLAIM LINE 13					CLAIM LINE 14				
ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT	ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT
			******* cc	******* cc				******* cc	******* cc

CLAIM LINE 15					CLAIM LINE 16				
ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT	ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT
			******* cc	******* cc				******* cc	******* cc

CLAIM LINE 17					CLAIM LINE 18				
ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT	ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	REIMBURSEMENT AMOUNT
			******* cc	******* cc				******* cc	******* cc

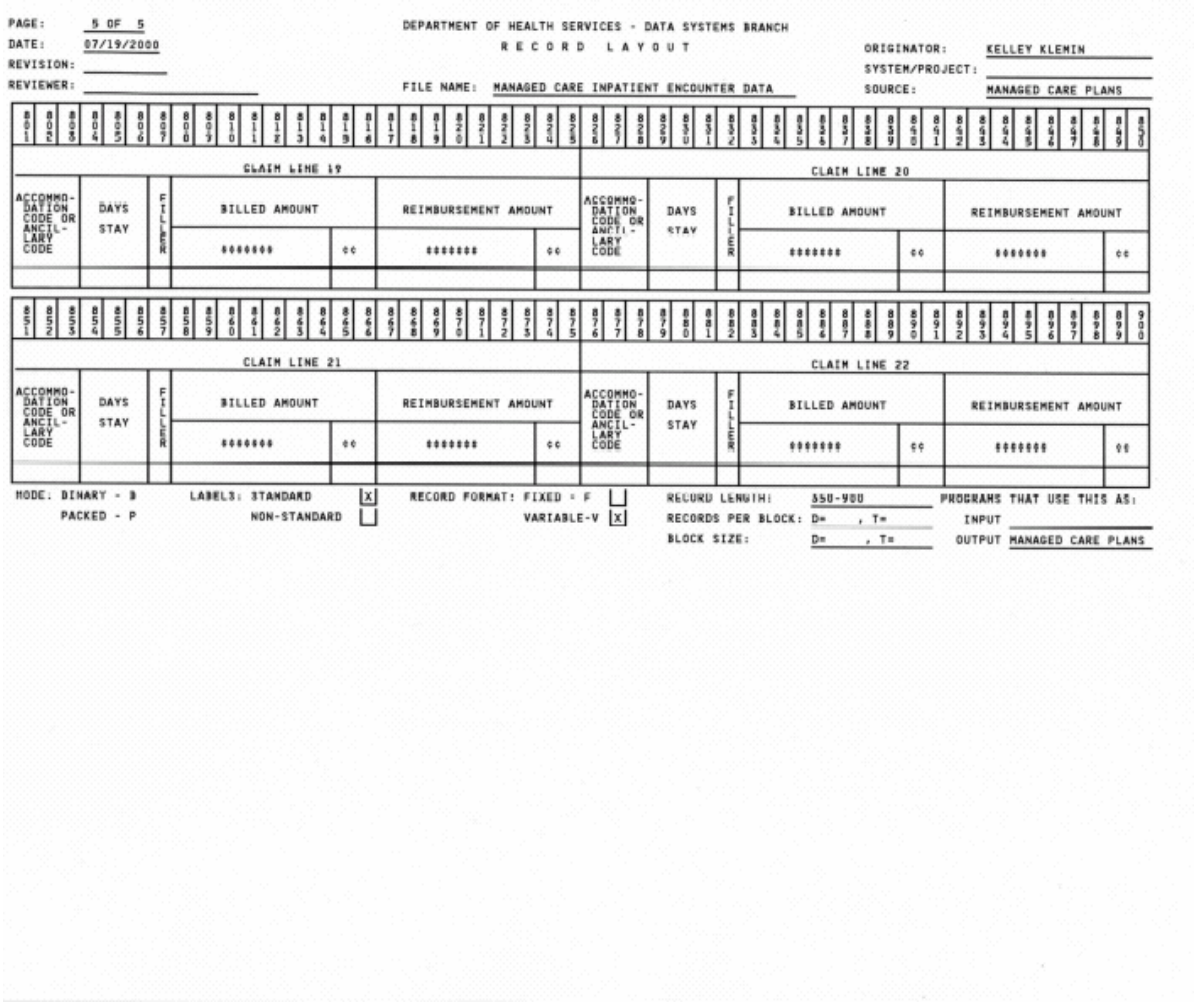
MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [ ]
VARIABLE-V [X]

RECORD LENGTH: 550-900
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS



PAGE: 5 OF 5
DATE: 07/19/2000
REVISION:
REVIEWER:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
RECORD LAYOUT
FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS

801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850

CLAIM LINE 19						CLAIM LINE 20					
ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	cc	REIMBURSEMENT AMOUNT	cc	ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	cc	REIMBURSEMENT AMOUNT	cc
			*******	cc	*******	cc				*******	cc	*******	cc

851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900

CLAIM LINE 21						CLAIM LINE 22					
ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	cc	REIMBURSEMENT AMOUNT	cc	ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	FILLER	BILLED AMOUNT	cc	REIMBURSEMENT AMOUNT	cc
			*******	cc	*******	cc				*******	cc	*******	cc

MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [ ]
VARIABLE-V [X]

RECORD LENGTH: 550-900
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS

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DATA

ELEMENTS

2006

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1. CLAIM REFERENCE NUMBER (CRN)

PURPOSE:

The CRN serves to uniquely identify any record, documenting an encounter, in order to locate and retrieve the record. The CRN also provides a way to calculate the length of time between the date of service to the date the record was received by the health plan and the date the record was sent to the State.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	13
FORMAT:	YDDDXXXXXXXXX
RECORD LOCATION:	Columns 1 through 13
REQUIRED ON:	All records

COMMENTS:

The first four characters indicate the Julian date, including a single digit year indicator, on which the health plan received the record. The last nine characters are assigned by the health plan.

Example: (5123123456789) The first four digits '5123' is May 3, 1995 in the Julian date format. The first digit '5' represents the year 1995 and '123' is the 123rd day of the year, or May 3. The nine numeric characters following the Julian date identify the record number and are in a format assigned by the health plan. For leap year, (i.e., 1996) one day must be added to the number of days after February 28, 1996. For example, March 1, 1996 becomes 6061 unlike March 1,1995 which was 5060.

A single encounter, defined as a "face-to-face" delivery of a medical service by a health care provider on a given date of service, can generate one or more records for the same recipient on the same day depending on the number of procedures performed by the provider. Each service or procedure rendered by a provider must be assigned a unique CRN by the health plan, except for hospital inpatient encounter records where up to 22 accommodation or ancillary codes can be entered on a single record (see data element 57).

2. PLAN CODE

PURPOSE:

To identify each health plan relative to each record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 14 through 18
REQUIRED ON:	All records

COMMENTS:

DHS currently assigns each health plan a unique plan code. Health plans must enter their assigned plan code in this field, including two leading zeroes, (i.e., 00160) for each encounter record. The plan code entered on each record must match the submitter identifier in the header record.

3. FORMAT CODE

PURPOSE:

Identifies the record format code on each record for one of five general types of encounters including medical outpatient, pharmaceutical, long term care, hospital inpatient acute care services.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 19
REQUIRED ON:	All records

COMMENTS:

Record Layout Format Codes = M, P, L, H

M = Medical Outpatient Services
Includes but is not limited to the following types of services: physician and nursing visits, surgical procedures, anesthesia services, laboratory tests, X-rays, physical therapy procedures, durable medical equipment, prosthetic and orthotic devices, transportation (i.e., ambulance), outpatient hospital services, dialysis, home health agency and vision services. Medical services must be reported in data element 39 (procedure codes) with either HCPCS,Outpatient and Home Health Services using UB-92 or CPT- 4 codes.

P = Pharmacy Services
Includes drug or medical supply items provided by a pharmacy. Use National Drug Codes (NDC).

L = Long Term Care Facility Charges.
Use UB-92

H = Hospital Inpatient Acute Care Charges.
Applies to each inpatient acute care hospital admission. Use UB 92 hospital accommodation and hospital ancillary codes for data element 57, hospital accommodation/ancillary codes.

4. PROGRAM CODE

PURPOSE:

To identify specific DHS program services rendered and included in the capitation.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 20
REQUIRED ON:	Not Required

COMMENTS:

This field can be left blank or filled with spaces.

Program Codes:

C = CHDP is also reported on the PM 160 sent to Child Health and Disability Prevention program. All CHDP services must be reported on PM 160 to receive credit.

S = For managed care plans contracted through California Children Services reporting encounter data

P = For managed care plans contracted through Department of Mental Health reporting Encounter Data.

5. ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER (CRN)

PURPOSE:

Indicates whether a previously submitted record is voided or corrected/ adjusted.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Column 21
REQUIRED ON:	Only when a previously submitted record is voided or corrected/adjusted

COMMENTS:

Enter an adjustment code only if the submitted record voids or corrects/adjusts a previously submitted record. The following two codes indicate the disposition of a previously reported record:

Adjustment Codes
1 = Void
2 = Corrected
Blank = Not an adjustment

VOID
It may be desired to completely void out a record of encounter information that was previously reported and submit corrections due to an error in procedure code, recipient identifying information, etc. If record was submitted to the State's system in error, use Adjustment Code "1" to void it out.

The contents of the record fields must be identical to the contents of the original except that:
1. the Adjust CRN should reflect the CRN of the original; and
2. the Adjustment Code must be "1", which will indicate to the States' system that
   a) this is not a duplicate procedure code, recipient identifier, etc., or that this is not a duplicate payment for the same service; i.e., that the service was not submitted twice; and
   b) that previously submitted fields, dollars, unit and days stay fields must be interpreted by the system as negative numbers which will serve to cancel or void out the amounts reported on the original record.

(DE #5 CONTINUED)

OTHER NEGATIVE ADJUSTMENT

ADJUST FOR PREVIOUS OVERPAYMENT: The contents of the records must be identical to the contents of the original record except that

1. the paid amount on the adjustment should reflect the difference between what has previously been reported;
2. the units and days field should be zero unless the payment difference resulted from a unit or day being subsequently denied in which case the number of units or days being denied should be reported;
3. the Adjustment CRN should reflect the CRN of the original records(s); and
4. the Adjustment Code must be "1" so that the dollar, unit(s) and days stay field(s) will be interpreted by the system as negative numbers.

CORRECTION ADJUSTMENT

If a record was sent to the system with an incorrect procedure code or recipient identifying information, or if for any reason it is desired to void out a previously reported record and submit a correct record, use the voiding procedure above and then submit the corrected record as it should have appeared and use Adjustment Code "2".

ADJUSTING FOR PREVIOUS UNDERPAYMENT: The contents of the submitted records must be identical to the contents of the original except that

1. the paid amount on the adjustment should reflect the difference between what has previously been reported and the higher amount that should have been reported;
2. the units and days field s should be zero unless the payment difference resulted from a unit or day being subsequently approved after previous denial, in which case the additional units or days approved should be reported;
3. the Adjustment CRN should reflect the CRN of the original record; and the Adjustment Code must be "2" so that the dollar, unit and days stay field(s) will be interpreted by the system as a positive number(s).

6. ADJUSTMENT CLAIM REFERENCE NUMBER (CRN)

PURPOSE:

Identifies the CRN of a previously submitted record that is voided or corrected/adjusted.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	13
FORMAT;	YDDDXXXXXXXXX
RECORD LOCATION:	Columns 22 Through 34
REQUIRED ON:	Only when an adjustment code is entered in data element 5

COMMENTS:

The adjustment CRN identifies the original claim reference number, in data element 1, pertaining to an encounter record that requires being voided or adjusted. This field also provides an audit trail of voided or adjusted records. Data element 6 must contain a CRN if an adjustment code is entered in data element 5, Adjustment Code. Conversely, if there is no adjustment code in data element 5, there must not be an adjustment CRN in data element 6.

If a previously submitted record does not require to be voided or corrected, this field is to be left blank or filled with spaces.

Cross reference with Adjustment Code for Claim Reference Number in data element 5.

7. MEDI-CAL BENEFICIARY IDENTIFICATION (BID)

PURPOSE:

Identifies a Medi-Cal recipient's eligibility for month of service. This data element includes the beneficiary' s county of residence code and aid code plus a State or county assigned number.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	14
FORMAT;	CCAAXXXXXXXXX
RECORD LOCATION:	Columns 35 Through 48
REQUIRED ON:	All records

COMMENTS:

The BID is supplied by the State to health plans each month and is not to be altered by the health plan when submitted back to the State on an encounter record. This data element must have the exact Medi-Cal number denoting eligibility for the month of service as supplied by the State or the county. The 14-character identification number may either be: (1) a county code, aid code, "9" and SSN assigned by DHS MEDS system for Social Security Administration's Supplemental Security Income/Supplemental Security Payment (SSI/SSP) eligible; or (2) a county code, aid code, case number, family budget unit and person number assigned by county welfare departments (for AFDC cash assistance and various medical assistance only programs.) The following box shows how to read the beneficiary ID:

C	C	A	A	X	X	X	X	X	X	X	X	X	X
3	4	1	0	9	1	2	3	4	5	6	7	8	9
3	4	3	0	1	2	3	4	5	6	7	8	9	0

CC = County Code
AA = Aid Code
X = '9' plus the SSN or Case number, Family Budget Unit, Person number assigned

Reporting Newborns
If submitting encounter data for a newborn for the month of birth and/or the following month, enter the mother's BID in this field.

8. SOCIAL SECURITY (SSN) OR CLIENT INDEX NUMBER (CIN)

PURPOSE:

Identifies the same recipient as indicated in data element 7 (Medi-Cal BID) and data element 9 (Medi-Cal recipient's name) by their SSN or DHS assigned Client Index Number (CIN).

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	Columns 49 Through 57
REQUIRED ON:	All records

COMMENTS:

The beneficiary's SSN is supplied by the State to the health plans. The recipient's SSN must not be altered when submitted back to the State on the encounter record. The first nine characters of the CIN or SSN from the Beneficiary Identification Card (BIC) are to be entered in the SSN field. The SSN or CIN appear as ten digits on the BIC. The last digit is a check digit. Only the first nine characters of the BIC are entered in the SSN field, NOT the final check digit.

This field may contain a pseudo SSN where the first byte is an '8' or '9' and the last byte is the letter 'P'. (Example: '8xxxxxxxP' or '9xxxxxxxP'.)

The CIN format is as follows: 9NNNNNNNA. It always starts with a 9, has 7 numerics and ends with one of the following alpha characters: A, C, D, E, F, G, H, M, N, S, T, U, V, W, X or Y. The CIN never ends with a P so that it cannot be confused with Pseudo SSNs.

<u>Reporting newborns</u>
If submitting encounter data for a newborn for the month of birth and/or the following month of birth, enter the mother's SSN in this field.

DO NOT USE ANY SPACES OR SPECIAL CHARACTERS SUCH AS HYPHENS.
USE LOW VALUES OR BLANKS ONLY

DE 9 NAME OF MEDI-CAL RECIPIENT

PURPOSE:

Identifies the Medi-Cal recipient by full or partial name.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	10
FORMAT;	Free format-Last name First name
RECORD LOCATION:	Columns 58 Through 67
REQUIRED ON:	All records

COMMENTS:

Use UPPER CASE only. The last name is entered first beginning in column 58 followed by the first name, space permitting. When comprised as part of a name, use of embedded hyphens are acceptable. If the last name is less than nine characters long, insert one space before the first character of the first name. If the last name is nine or 10 characters long, no part of the first name can be entered in this field. This field is left justified with trailing blanks.

If submitting data for a newborn, using the mother's identification number in data element 7, (BID), enter the infant's name in this field. If the infant has not yet been named, enter the mother's last name and, space permitting, the following 2 or 3 byte identifiers: BB (baby boy) or BG (baby girl). For multiple births, enter BB1 (baby boy #1), BG1 (baby girl #1), etc.

Examples of entering full and partial names:

M	A	Y	A		R	I	O		
W	A	L	L	O	O	N		B	I
R	O	D	R	I	G	U	E	Z	

DO NOT USE COMMAS OR APOSTROPHES.

10. BIRTH DATE OF MEDI-CAL RECIPIENT

PURPOSE:

Identifies the Medi-Cal recipient's date of birth (DOB)

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	8
FORMAT;	CCYYMMDD
RECORD LOCATION:	Columns 68 Through 75
REQUIRED ON:	All records

COMMENTS:

Example: July 31, 1995 or 31 July 1995 or 7/31/95 would be entered in this field only as 19950731.

If reporting data for a newborn using the mother's ID, enter the infant's date of birth in this field.

Do not use special characters such as slashes, commas or hyphens

11. SEX CODE OF MEDI-CAL RECIPIENT

PURPOSE:

Identifies the sex of the Medi-Cal recipient.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha (UPPER CASE)
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Column 76
REQUIRED ON:	All records

COMMENTS:

USE UPPER CASE ONLY WHEN ENTERING ONE OF THE FOLLOWING CODES.

Acceptable codes are: M = MALE
F = FEMALE

12. ETHNIC/RACE CODE OF MEDI-CAL RECIPIENT

(Leave this field blank. FOR STATE USE ONLY)

PURPOSE:

Identifies ethnicity of Medi-Cal recipient.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Column 77
REQUIRED ON:	Not required

COMMENTS:

Entries in this field are only made by the State. Health plans are to leave this field blank.

Race/Ethnicity Codes

0 - Unknown
1 - White
2 - Hispanic
3 - Black
4 - Other Asian or Pacific Islander
5 - American Native or American Indian
7 - Filipino
8 - No Valid Data Reported (MEDS generated)
A - Amerasian
C - Chinese
H - Cambodian
J - Japanese
K - Korean
M - Samoan
N - Asian Indian
P - Hawaiian
R - Guamanian
T - Laotian
V - Vietnamese

13. PROVIDER NUMBER (REPORTING/BILLING)

PURPOSE:

Identifies the Medi-Cal provider number or state license number of an individual, group, clinic, or facility that has billed a health plan for, or reported a capitated encounter service.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	12
FORMAT;	X XXXXXXXXXX
RECORD LOCATION:	Columns 78 through 89
REQUIRED ON:	All records

COMMENTS:

This is one of three data elements, including data elements 21 and 42, identifying providers' Medi-Cal or state license numbers. Data element 13 must always contain a provider number for each record in order to identify the provider billing the health plan or reporting the delivery of a capitated service. If the provider does not have an individual or group Medi-Cal provider number, the provider's State license number must be used. When the service is reported by a Clinic the Medi-Cal provider number is to be reported. If the clinic does not have a Medi-Cal provider number, the State clinic license number must be used. If the service is reported/billed by a health facility, the Department of Health Services assigned facility number must be entered. When making entries in this field, enter the entire provider or license number, plan provider identifier number, tax identifier number, or national provider identification number, including all leading and trailing characters.

This field is left justified with trailing blanks.

Cross-reference this field with data element 14, provider name.

14. PROVIDER NAME (REPORTING/BILLING)

PURPOSE:

Identifies the name of the provider billing for, or reporting a capitated service.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	28
FORMAT;	X (28)
RECORD LOCATION:	Columns 90 through 117
REQUIRED ON:	All Records

COMMENTS:

This field contains the name of the physician, facility, clinic, Ambulance Company, or whoever is billing for or reporting the delivery of an encounter service as indicated in data element 13, provider number.

If reporting an individual's name, the last name must precede the first name with one space separating the two as in the following example:

ZIMMERMAN ROBERT

If reporting the name of a clinic, hospital, health plan or anything other than an individual provider's name, enter the facility or company's name as it normally appears, i.e., Memorial Hospital.

This field must be left justified.

Cross-reference with data element 13, provider number.

15. ZIP CODE OF PROVIDER (RENDERING)

PURPOSE:

Identifies the zip code where the reported encounter service was rendered.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	5
FORMAT;	XXXXX
RECORD LOCATION:	Columns 118 through 122
REQUIRED ON:	All records

COMMENTS:

Enter the zip code where the reported service was rendered.

Cross-reference with data element 16, County Code.

Cross-reference with data element 42, rendering provider, when field is filled.

16. COUNTY CODE OF PROVIDER (RENDERING)

PURPOSE:
Identifies the county where the reported encounter service was rendered.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	2
FORMAT;	XX
RECORD LOCATION:	Columns 123 through 124
REQUIRED ON:	All records

COMMENTS:
Enter the county code where the service was rendered. Cross reference with data element 15, zip code.

CODE	COUNTY	CODE	COUNTY
01	Alameda	31	Placer
02	Alpine	32	Plumas
03	Amador	33	Riverside
04	Butte	34	Sacramento
05	Calaveras	35	San Benito
06	Colusa	36	San Bernardino
07	Contra Costa	37	San Diego
08	Del Norte	38	San Francisco
09	El Dorado	39	San Joaquin
10	Fresno	40	San Luis Obispo
11	Glenn	41	San Mateo
12	Humboldt	42	Santa Barbara
13	Imperial	43	Santa Clara
14	Inyo	44	Santa Cruz
15	Kern	45	Shasta
16	Kings	46	Sierra
17	Lake	47	Siskiyou
18	Lassen	48	Solano
19	Los Angeles	49	Sonoma
20	Madera	50	Stanislaus
21	Marin	51	Sutter
22	Mariposa	52	Tehama
23	Mendocino	53	Trinity
24	Merced	54	Tulare
25	Modoc	55	Tuolumne
26	Mono	56	Ventura

DE 16-
CONTINUED

CODE	COUNTY	CODE	COUNTY
27	Monterey	57	Yolo
28	Napa	58	Yuba
29	Nevada	99	Out of State
30	Orange		

17. PROVIDER TYPE CODE

PURPOSE:

Identifies the type of provider that rendered the reported service or procedure.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	2
FORMAT;	XX
RECORD LOCATION:	Columns 125 through 126
REQUIRED ON:	All records

COMMENTS:

The provider type indicated in this field can be, but is not necessarily, the same as the billing or reporting provider indicated in data elements 13 and 14, provider number and provider name. The provider type refers to the provider who rendered the service. The provider type must be consistent with the type of license held by the provider and the type of service reported on the encounter record.

If provider type codes 22 (physician group) or 26 (physician) are entered in this field, then a physician code must be entered in data element 18. Physicians or physician groups must be coded either a 22 or 26.

See the following page for a list of current provider type codes, updated July 20, 2006,.

Use of code 99 Miscellaneous Medical should only be used when unable to place the rendering provider type into one of the listed provider types.

(DE 17 continued) PROVIDER TYPE CODES

CODE	DESCRIPTION	CODE	DESCRIPTION
DN	Dentist	41	Community Clinics
01	Adult Day Care Center	42	Chronic Dialysis Clinics
02	Assistive Device & Sick Room Supplies	43	Multi-specialty Clinics
03	Audiologist	44	Surgical Clinics
04	Blood Bank	45	Exempt from Licensure Clinics
05	Certified Nurse Midwife	46	Rehabilitation Clinics
06	Chiropractor	47	Employer/Employee Clinics
07	Certified Pediatric Nurse & Certified Nurse	48	County Clinics not Associated with Hospital
08	Christian Science Practioners	49	Birthing Centers-Primary Care Clinics
09	Clinical Laboratories	50	Clinic-Otherwise Undesignated
10	Group Certified Pediatric NP & Certified Family NP	51	Outpatient Heroin Detoxification Center
11	Fabricating Optical Laboratory	52	Alternative Birth Centers-Specialty Clinics
12	Dispensing Opticians	53	Breast Cancer Early Detection Program
13	Hearing Aide Dispensers	54	Expanded Access to Primary Care
14	Home Health Agencies (HHA)	55	Local Education Agency
15	Community Hospital Outpatient Departments	56	Respiratory Care Practitioner
16	Community Hospital Inpatient	57	EPSDT Supplement Services Provider
17	Certified Long Term Care Facility (LTC)	58	Health Access Program
18	Nurse Anesthetists	59	HCBS Congregate Living Health Facilities, Type A Licensure
19	Occupational Therapists	60	County Hospital Inpatient
20	Optometrists	61	County Hospital Outpatient
21	Orthotists	62	Group Respiratory Care Practitioner
22	Physicians Group	63	Licensed Building Contractors
23	Optometric Group	64	Employment Agency
24	Pharmacies/Pharmacist	65	Pediatric Subacute Care/LTC
25	Physical Therapists	66	Personal Care Agenc
26	Physicians	67	Individual Nurse Providers (Waivers)
27	Podiatrists	68	HCBS Benefit Provide
28	Portable X-ray Laboratory	69	Professional Corporation
29	Prosthetists	70	Acute Psych Hosp
30	Ground Medical Transportation	72	Mental Health Inpatient
31	Psychologists	73	AIDS Waiver Provider
32	Certified Acupuncture	74	Multi-Purpose Senior Services Program
33	Genetic Disease Testing Fund	75	Tribal Health Plan
34	Medicare Crossover Provider Only	80	California Children's Service (CCS)/Genetically Handicapped Person Program (GHPP) Non- Dent
35	P.L. 95-210 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)	81	CCS/GHPP – Institution
36	HCB – Cert Home Health Agency	82	Licensed Midwife Program
37	Speech Therapist	84	Independent DX Testing Facility (Crossover)
38	Air Ambulance Transportation Service	85	CNS Crossover Provider Only

(DE 17 continued)	PROVIDER TYPE CODES		
39	Certified Hospice Service	90	Out-Of-State Provider
40	Free Clinics	92	Resid. Care Fac. For the Elderly RCFE
93	Care Coordinator (CCA)		
95	Private Non-Profit Proprietary Agency		
98	Miscellaneous		
99	Dentists		

18. PHYSICIAN SPECIALTY CODES

PURPOSE:

Identifies the area of specialization for a physician who rendered the reported service.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	2
FORMAT;	XX
RECORD LOCATION:	Columns 127 through 128
REQUIRED ON:	Medical records only

COMMENTS:

If data element 17, provider type, is coded 22 (physician group) or coded 26 (physician) enter the appropriate physician specialty code for data element 18.
If the provider type is not a physician (22 or 26) as indicated in data element 17, then leave this field blank or fill with spaces.

See the following page for a list of physician specialty codes.

Cross-reference with data element 17, provider type.

(DE 18 continued)

PHYSICIAN SPECIALTY CODES		
CODE DESCRIPTION	CODE DESCRIPTION	CODE DESCRIPTION
01 General Practice	21 Pathologic Anatomy Clinical Pathology (D.O. Only)	42 Nuclear Medicine
02 General Surgery	22 Pathology (M.D. Only)	43 Pediatric Allergy
03 Allergy	23 Peripheral Vascular Disease or Surgery (D.O. Only)	44 Public Health
04 Otology, Laryngology, Rhinology	24 Plastic Surgery	45 Nephrology
05 Anesthesiology	25 Physical Medicine & Rehabilitation	46 Hand Surgery
06 Cardiovascular Disease (M.D. Only)	26 Psychiatry-Child	47 Miscellaneous
07 Dermatology	27 Psychiatry Neurology (D.O. Only)	66 Emergency Medicine
08 Family Practice	28 Proctology (Colon & Rectal)	67 Endocrinology
09 Gynecology (D.O. Only)	29 Pulmonary Diseases (M.D. Only)	68 Hematology
10 Gastroenterology (M.D. Only)	30 Radiology	70 Clinic (mixed specialty)
11 Aviation (M.D. Only)	31 Roentgenology, Radiology (M.D. Only)	77 Infectious Disease
12 Manipulative Therapy (D.O. Only)	32 Radiation Therapy (D.O. Only)	78 Neoplastic Diseases
13 Neurology (M.D. Only)	33 Thoracic Surgery	79 Neurology-Child
14 Neurological Surgery	34 Urology; Urological Surgery	83 Rheumatology
15 Obstetrics (D.O. Only)	35 Pediatric Cardiology M.D. Only)	84 Surgery-Head and Neck
16 Obstetrics-Gynecology (M.D. Only)	36 Psychiatry	85 Surgery-Pediatric
17 Ophthalmology, Otolaryngology,	38 Geriatrics	89 Surgery - Traumatic

PHYSICIAN SPECIALTY CODES		
CODE DESCRIPTION	CODE DESCRIPTION	CODE DESCRIPTION
Rhinology (D.O. Only)		
18 Ophthalmology	39 Preventive (M.D. Only)	90 Pathology-Forensic
19 Dentist (D.M.D. &D.D.S.)	40 Pediatrics	91 Pharmacology-Clinical
20 Orthopedic Surgery	41 Internal Medicine	99 Unknown

19. BEGINNING DATE OF SERVICE

PURPOSE:

Identifies the beginning date of service reported for each record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	8
FORMAT;	CCYYMMDD
RECORD LOCATION:	Columns 129 through 136
REQUIRED ON:	All Records

COMMENTS:

The first two bytes represent the century, followed by two bytes indicating the year of the century, two bytes for the month of the year and two bytes for the day of the month. For example, the date of October 19, 1995 would be entered as 19951019.

The beginning date of service shall be the first date of service regardless of payment date and always be equal to or earlier than the ending date of service.

This field must be numeric and greater than zero.

Do not use special characters such as slashes, commas or hyphens.

20. ENDING DATE OF SERVICE

PURPOSE:

Identifies the ending date of service reported for each record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	8
FORMAT;	CCYYMMDD
RECORD LOCATION:	Columns 137 through 144
REQUIRED ON:	All Records

COMMENTS:

The first two bytes represent the century, followed by two bytes indicating the year of the century, two bytes for the month of the year and two bytes for the day of the month. For example, the date of November 16, 1995 would be entered as 19951116.

The ending date of service shall be the last date of service pertaining to the reported record. When the reported service begins and ends on the same day, the beginning and ending dates of service shall be the same. The date entered in this field must never be earlier than the date entered in data element 19, beginning date of service.

This field must be numeric and greater than zero.

Do not use special characters such as slashes, commas or hyphens.

21. REFERRING/PRESCRIBING/ADMITTING PROVIDER

PURPOSE:
Identifies an individual provider's number who has either referred, prescribed medication or admitted a patient into a hospital.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	12
FORMAT;	XXXXXXXXXXX
RECORD LOCATION:	Columns 145 through 156
REQUIRED ON:	Medical Outpatient records resulting from referrals, All pharmacy records, All hospital inpatient records, and All long term care records.

COMMENTS:

If the referring or prescribing or admitting provider does not have a Medi-Cal provider number, enter the provider's State license number. Do not enter a group provider or facility license number in this field.

Referring Physician: If the record format is 'M' (medical outpatient) and the reported service resulted from a referral from the patient's Primary Care Physician (PCP), enter the PCP's provider or license number. The referring physician must never be the same as the billing/reporting or rendering provider as indicated in data elements 13 or 42. If no referral was linked with this reported service, leave this field blank or fill it with spaces.

Prescribing Physician: For all pharmacy records, enter the provider number, license number, or Drug Enforcement Authority number of the physician who prescribed the medication or authorized the medical supply.

Admitting Physician: For all hospital and long term care records, enter either the Medi-Cal provider number or the State license number of the physician who admitted the patient into the hospital.

Left justify this field with trailing blanks.

22. PRIOR AUTHORIZATION OR PRIMARY CARE PHYSICIAN (PCP) REFERRAL INDICATOR

PURPOSE:
Identifies whether the service rendered required a referral or prior authorization from the PCP or health plan.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Column 157
REQUIRED ON:	Medical, Hospital and Long Term Care records resulting from referrals or prior authorizations

COMMENTS:

If the service reported on this record was the result of a referral or required prior authorization from the PCP or health plan, enter the appropriate indicator code listed below. If no referral or prior authorization preceded this reported service, leave this field blank or fill with spaces.

INDICATOR CODES:

R - Referral from a PCP was required prior to this service being rendered.

P - Prior Authorization was required from the PCP or health plan prior to this service being rendered.

B - Both a PCP referral and prior authorization was required prior to this service being rendered.

Entries in this field must be in CAPS.

23. PRIMARY DIAGNOSIS (ICD 9 CM)

PURPOSE:
Identifies the diagnosis code for the principle condition of the patient.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	5
FORMAT;	XXXXX
RECORD LOCATION:	Column 158 through 162
REQUIRED ON:	Hospital, Long Term Care and Medical Outpatient records depending on type of provider and procedure codes (see below).

COMMENTS:

Enter all letters and/or numbers of the International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM). The ICD -9 code can be 3 to 5 characters. The three digit code is the most general description of the patient's condition. The 4th and 5th digits provide a more detailed description. Do not enter a decimal point when entering the code.

For all hospital and long term care records; enter the patient's diagnosis upon admission to the facility.

For Outpatient Medical records, the primary diagnosis must be entered if the service was rendered by any one of the following types of providers:

05-Certified Nurse Midwife	34-Rural Health Clinic
06-Chiropractor	35-PL-95-210 Rural Health Clinic and Federally Qualified Health Center
07-Certified Pediatric or Family Nurse Practitioner	40-Free Clinic
10-Group Certified Pediatric or Family Nurse Practitioner	41-Community Clinic
22-Physician Group	43-Multispecialty Clinic
26-Physician	44-Surgical Clinic
27-Podiatrist	46-Rehab Clinic
31-Psychologist	49-Alternative Birthing Center-Primary Care Clinic
32-Acupuncturist	

The ICD-9 diagnosis codes are required on the encounter/claims for laboratory/pathology. These will be identified by the use of the CPT 80000 series or codes on reported services.

For all other provider types, entries in this field are optional. Cross-reference this field with data Element 17, provider type.

24. SECONDARY DIAGNOSIS (ICD 9 CM)

PURPOSE:

Identifies the diagnosis code for the secondary condition, if any, of the patient.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	5
FORMAT;	XXXXX
RECORD LOCATION:	Column 163 through 167
REQUIRED ON:	Hospital, Long Term Care and Medical Outpatient records depending on type of provider (see data element 23, primary diagnosis).

COMMENTS:

Enter all letters and/or numbers of the ICD-9-CM code for the secondary diagnosis including fourth and fifth digits, if applicable. Do not enter a decimal point when entering the code.

Left justify this field with trailing blanks.

If the patient does not have a secondary diagnosis, this field can be blank or filled with spaces.

See DE #23

25. TERTIARY DIAGNOSIS (ICD 9 CM)

PURPOSE:

Identifies the diagnosis code for the tertiary condition of the patient.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	5
FORMAT;	XXXXX
RECORD LOCATION:	Column 168 through 172
REQUIRED ON:	Hospital, Long Term Care and Medical Outpatient records depending on type of provider (see data element 23, primary diagnosis).

COMMENTS:

Enter all letters and/or numbers of the ICD-9-CM code for the tertiary diagnosis including fourth and fifth digits, if applicable. Do not enter a decimal point when entering the code.

Left justify this field with trailing blanks.

If the patient does not have a tertiary diagnosis, this field can be blank or filled with spaces.

See DE #23

26. FAMILY PLANNING INDICATOR

PURPOSE:

Identifies the provision of family planning services.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Column 173
REQUIRED ON:	Medical outpatient records reporting family planning services.

COMMENTS:

If family planning services were provided and reported on this record, enter the appropriate code (1 or 2) in this field.

If no family planning services were provided, leave this field blank or fill with spaces.

FAMILY PLANNING INDICATOR CODES:

1 - Family Planning/Sterilization

2 - Family Planning/Other

27. ADJUDICATION STATUS CODE

PURPOSE:

To identify whether the service rendered was provided on a capitated or non-capitated basis. If non-capitated, this field also indicates whether the health plan paid, or denied payment for a service, procedure or supply.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha
NUMBER OF BYTES(S) :	1
FORMAT;	X
RECORD LOCATION:	Column 175
REQUIRED ON:	All Records

COMMENTS:

If the service was provided by a provider having a capitated or negotiated rate arrangement with the health plan then enter code C in this field.

If the service was provided by a provider not having a capitated or negotiated rate arrangement with the health plan, and the health plan paid the provider for the specific service rendered, enter code P.

Enter the codes in CAPS.

ADJUDICATION STATUS CODES FOR ALL CLAIM TYPES IDENTIFIED AS DATA ELEMENT #3 FORMAT CODE:

C –Capitated	Service provided on a capitated or negotiated rate arrangement basis.
P –Paid	Plan paid provider for specific service, procedure or supply.

28. ADJUDICATION DATE

PURPOSE:

Identifies the date this record was adjudicated.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	8
FORMAT;	CCYYMMDD
RECORD LOCATION:	Columns 176 through 183
REQUIRED ON:	All Records

COMMENTS:

Entries in this field must be numeric and greater than zero.

The first two bytes are the century, followed by two bytes for the year, two bytes for the month and two bytes for the day of the month. For example, October 31, 2005 would be entered as 20051031.

If the record resulted from a capitated service (i.e., adjudication status, code C) enter the date the record was processed by the health plan.

If the record resulted from a service provided as non-capitated, fee for service arrangement, (i.e., adjudication status, code “P”) enter the date when the health plan determined (adjudicated) to pay for the reported service or supply.

Cross-reference with data element 27, adjudication status.

Data element 29, Date of Payment, must be equal to or later than the adjudicated date.

29. DATE OF PAYMENT BY PLAN (CHECK DATE)

PURPOSE:

Identifies the date payment was issued to the billing provider by the health plan for the service provided on a non-capitated, fee for service basis.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	8
FORMAT;	CCYYMMDD
RECORD LOCATION:	Columns 184 through 191
REQUIRED ON:	Records with adjudication status P in data element 27

COMMENTS:

The first two bytes are the century, followed by two bytes for the year, two bytes for the month and two bytes for the day of the month. For example, November 1, 2005 would be entered as 20051101.

If data element 27, adjudication status is code P, enter the date of payment.
The date of payment must be equal to or later than the adjudication date.

If the adjudication status is code C or D, zero-fill this field.

Cross-reference this field with data element 27, adjudication status.

30. BILLED AMOUNT

PURPOSE:

Identifies the amount the provider billed the health plan for this service(s) reported on this record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	All Records: Columns 192 through 200 Hospital Inpatient records (detail): Segment 1: columns 358 through 366 Segment 2: columns 383 through 391 Refer to the hospital record layout for the location of additional billed amount fields for the remaining 20 detail segments.
REQUIRED ON:	All Records with adjudication status P in data element 27

COMMENTS:

If the adjudication status (data element 27) is C, capitated, enter an appropriate amount (optional) or zero fill this field. When the adjudication status is P (paid), the billed amount is entered in this field.

This field is right justified with leading zeroes. The last two bytes are considered cents.

Example: $25,450.13 would be entered as 002545013

For hospital records, the total billed amount is also entered in this field in columns 192 - 200 and represents the sum of the billed amounts for all hospital charges.

Enter the billed amount for each type of hospital accommodation and ancillary service (data element 57). The billed amount for the first claim line is entered in column 358 - 366. Enter the billed amount for any additional reported accommodation/ancillary codes in the appropriate columns. Sum the billed amount from all claim line segments (i.e., accommodation and ancillary services) and enter the total billed amount in columns 192 - 200.

Cross-reference this field with data element 27, adjudication status.

31. REIMBURSEMENT AMOUNT

PURPOSE:

Identifies amount paid to the provider by the health plan for the service(s) reported on this record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	All Records: Columns 201 through 209 Hospital Inpatient records (detail): Segment 1: columns 367 through 375 Segment 2: columns 392 through 400 Refer to the hospital record layout for the location of additional reimbursement amount fields for the remaining 20 segments.
REQUIRED ON:	All Records with adjudication status P in data element 27

COMMENTS:

If the adjudication status (data element 27) is C, capitated, enter an appropriate paid amount (optional) or zero fill this field. When the adjudication status is P (paid), the paid amount is entered in this field.

This field is right justified with leading zeroes. The last two bytes are considered cents.

Example: $25,450.13 would be entered as 002545013

For hospital records, the total paid amount is also entered in this field in columns 201 - 209 and represents the sum of the paid amounts for all hospital charges reported on the record.

Enter the paid amount for each type of hospital accommodation and ancillary service (data element 57). The paid amount for the first segment is entered in column 367 - 375. Enter the paid amount for any additional reported accommodation/ancillary codes in the appropriate columns. Sum the paid amount from all claim line segments (i.e., accommodation and ancillary services) and enter the total paid amount in columns 201 - 209.

Cross-reference this field with data element 27, adjudication status.

32. PATIENT LIABILITY AMOUNT (Share of Cost)

PURPOSE:

Amount owed by the recipient to the provider for services or supplies provided and reported on this record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	Columns 210 through 218
REQUIRED ON:	Records with recipients having share of cost

COMMENTS:

This field is right justified with leading zeroes. The last two bytes are considered cents.

Example: $731.48 would be entered as 000073148

If the recipient has no share cost obligation for the service reported on this record, fill this field with zeroes.

33. MEDICARE DEDUCTIBLE AMOUNT

PURPOSE:

Indicates the amount of the Medicare deductible for the service reported on this record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	Columns 219 through 227
REQUIRED ON:	Records having a Medicare deductible

COMMENTS:

If there is no Medicare deductible for this record, or if the adjudication status in data element 27 is code C, zero fill this field.

If the recipient is Medicare eligible and the encounter service is allowed by Medicare, enter the deductible amount, if any.

This field is right justified with leading zeroes. Last two digits are considered cents.

For example, $1,223.47 would be entered as 000122347

34. MEDICARE CO-INSURANCE AMOUNT

PURPOSE:

Identifies co-insurance amount for Medicare services.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	Columns 228 through 236
REQUIRED ON:	Not Required

COMMENTS:

Zero fill this field.

35. OTHER HEALTH COVERAGE AMOUNT

PURPOSE:

Identifies the amount paid by insurance carrier or third party for the service reported on this record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTES(S) :	9
FORMAT;	XXXXXXXXX
RECORD LOCATION:	Columns 237 through 245
REQUIRED ON:	Records having other insurance payments associated with the reported service

COMMENTS:

If a third party or insurance carrier provided a payment on behalf of the recipient for this service, enter the amount paid.

If there was no payment by an insurance carrier or third party for the service reported on this record, or the adjudication status was code C, (capitated), zero fill this field.

This field is right justified with leading zeroes. The last two bytes are considered cents.

For example, $1.49 would be entered as 000000149

Cross reference with data element 27, adjudication status.

36. DATA ELEMENT

FILLER – NOT USED AT THIS TIME IN CAPTITATED PROGRAMS

37. DATA ELEMENT

FILLER – NOT USED AT THIS TIME IN CAPTITATED PROGRAMS

38. PLACE OF SERVICE (POS)

PURPOSE:

Identifies where the service was rendered.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES(S) :	2
FORMAT;	XX
RECORD LOCATION:	Columns 301 through 302 for medical records. Columns 321 through 322 for pharmacy records
REQUIRED ON:	Medical Outpatient and Pharmacy Records

COMMENTS:

Place of Service Codes are maintained for outpatient services by the Centers for Medicare & Medicaid Services and for hospitals, skilled nursing facilities and other providers utilizing UB 92 codes by NUBC.

For pharmacy records, if the POS is a long-term care facility, enter code 31, 32, 54, 92 or 93. For all other pharmacy records enter code 01, Pharmacy.

To obtain current listing of POS codes published by CMS use the following URL:
www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf

The codes generated by the NUBC are located in the UB92 code reference books. The place of service codes are the first two digits of the Type of Facility code.

(DE 38 continued)

For outpatient medical and vision records, enter one of the following appropriate CMS Place of Services Codes: (The 90 series was developed by DHS)

01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
09	Prison-Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile
20	Urgent Care Facility
21	Inpatient
22	Outpatient
23	Emergency Room (Hospital)
24	Ambulatory Surgical
25	Birthing
26	Military Treatment Ctr.
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
50	Federally Qualified Health Center (FQHC)
51	Inpatient Psychiatric Facility

52	Psych. Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/MR
55	Residential Treatment Ctr/Substance Abuse
56	Psychiatric Residential Treatment Ctr
57	Non-Residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	Independent Kidney Disease Treatment Ctr
71	State or Local Public Health Clinic
72	Rural Health Clinic (RHC)
81	Independent Laboratory
91	Nursing Facility Level B (Adult Subacute)
92	Intermed Care Facility (DD, ICF-DD)
93	Intermed Care Facility Nursing (DD, ICF-DD)
94	Non-Home
95	Mobile Van
96	Pediatric Subacute
97	Transitional Inpatient Care
99	Other place of service not identified

(DE 38 continued)

UB92 TYPE OF FACILITY CODE used for encounters submitted by hospitals, long term care facilities, home health agencies, hospital clinics, hospice, and others as noted on the listing:

CODE	TYPE OF FACILITY DESCRIPTION
11	Hospital-Inpatient, Medical assistance facilities, LTC with ALOS geater than 25 days, Rehab hosp. or distinct part unit, Pediatric hospitals, Psychiatric hosp. or distinct part, Critical access hospitals
12	Hospital – inpatient (Part B)
13	Hospital – outpatient
14	Hospital- other Part B
18	Hospital – swing bed
21	SNF – inpatient
22	SNF – inpatient Part B
23	SNF – outpatient
28	SNF – swing bed
32	Home Health
33	Home Health
34	Home Health (Part B only)
41	Religious nonmedical health care institutions – hospital inpatient
43	Religious nonmedical health care institutions – home health services
71	Clinic – rural health
72	Clinic - ESRD
73	Clinic – FQHC
74	Clinic – OPT
75	Clinic – CORF
76	Clinic – CMHC
81	Non-hospital based hospice
82	Hospital based hospice
83	Ambulatory surgery center (ASC)
85	Critical access hospital outpatient

39. PROCEDURE CODE (CPT-4, HCPCS OR UB-92 CODES)

PURPOSE:
Identifies specific medical services and procedures that were performed and medical supplies or materials provided.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 303 through 307
REQUIRED ON:	Medical Outpatient records

COMMENTS:

As outlined in the MMCD All Plan Letter 02005, the HCFA Common Procedure Coding System (HCPCS) Levels II, Uniform Billing Codes (UB-92) and Current Procedural Terminology (CPT- 4) codes identify and describe types of services and procedures rendered by health care professionals. Most codes appear in the Provider Manuals from Electronic Data Systems or the Physicians' Current Procedural Terminology manual updated and published yearly by the American Medical Association. CPT codes also include condition codes to be used in conjunction with the appropriate CPT code describing procedure done. HCPCS Levels II is used to bill for supplies, equipment, pharmaceuticals and services/procedures performed by allied medical professionals such as Dentists and optometrists. HCPCS are also used to for certain services and procedures not defined in CPT. UB –92 codes are available from the National Uniform Billing Committee. CPT codes are used for reporting medical, surgical and diagnostic services performed by physicians. UB92 codes are used for patient status, accommodation revenue codes, ancillary revenue codes, and condition codes.

Procedure code formats are as following:

HCPCS - 1 Alpha character and 4 numeric characters

CPT-4 - 5 Numeric characters

UB-92 - 4 Numeric characters right justified with a leading blank.

UB-92- 3 Numeric characters right justified with two leading blanks

(DE 39 – continued)

There should be no entries in this field for hospital, pharmacy or long term care records. CPT 4 or ICD-9 Surgical procedure codes for hospital inpatient records are entered in data elements 53 and 54, primary and secondary surgical procedures.

State of California—Health and Human Services Agency
Department of Health Services

DIANA M. BONTA, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

August 7, 2002

MMCD All Plan Letter 02005

TO: [X] County Organized Health System Plan (COHS)
[X] Geographic Managed Care (GMC) Plans
[X] Prepaid Health Plans (PHP)
[X] Primary Care Case Management (PCCM) Plans
[X] Two-Plan Model Plans

FROM: Cheri Rice, Chief
Medi-Cal Managed Care Division

SUBJECT: EMERGENCY SERVICES MEDICAL CLAIM CODING AND DOCUMENTATION GUIDELINES

This document is to clarify Department of Health Services (DHS) standards for coding of medical claims and the underlying supporting documentation for professional emergency services. The standard followed by the DHS Medi-Cal program can be found in Section 51050 of Title 22, California Code of Regulations, "Health Care Financing Administration's Common Procedure Coding System." The Health Care Financing Administration's Common Procedure Coding System (HCPCS) consists of the Physician's Current Procedural Terminology (CPT), published by the American Medical Association, also commonly cited as HCPCS Level I and HCPCS Level ll. Level l codes are codes that typically relate to procedure and evaluation codes used by medical providers when providing services. Level II codes typically relate to supplies, equipment, pharmaceuticals and services/procedures performed by allied medical professionals such as Dentists and Optometrists. Medi-Cal beneficiary claims for emergency services in the Medi-Cal Fee for Service and Medi-Cal Managed Care Programs should be billed and adjudicated using the most recent HCPCS Level l and Level ll codes and documentation standards.

Do your part to help California save energy. To learn more about saving energy, visit the following web site:
www.consumerenergycenter.org/flex/index.html

714 P Street, P.O. Box 942732, Sacramento, CA 94234-7320
(916) 654-8076
Internet Address: www.dhs.ca.gov

40. PROCEDURE MODIFIER CODE

PURPOSE:

For Medical records - To determine any special external circumstances connected to the procedure or service reported in data element 39, procedure code.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	2
FORMAT:	XX
RECORD LOCATION:	Columns 308 through 309
REQUIRED ON:	Medical Outpatient Records

COMMENTS:

For medical records reporting no special circumstances associated with the procedure, this field can be left blank or filled with spaces.

All current CPT - 4 and HCPC procedure modifier codes are allowable in addition to Medi-Cal designated modifier codes

Cross-reference this field with data element 39, procedure code.

41. MEDICAL OUTPATIENT PROCEDURE QUANTITY

PURPOSE:

Identifies the quantity or number of units of services, procedures or supplies provided.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 310 through 314
REQUIRED ON:	Medical Outpatient Records

COMMENTS:

This numeric field describes the quantity related to the procedure code reported in data element 39. The reported quantity may be the number of medical "visits", surgical "lesions", number of "items" or "units" of service, some which are defined in units of "time". For example, physicians may report the number of visits, surgeries, anesthesia units, injections, lab procedures, x-rays, etc. Units of "time" may be reported as day, hour or minute increments. For example, the delivery of one hour of anesthesia services, in 15 minute increments, would be reported as 00004 units. The contents of this field must be compatible with type of service rendered. This field should never contain a “0".

Cross-reference this field with data element 39, procedure code.

This field is right justified with leading zeroes.

DE 42. RENDERING PROVIDER NUMBER

PURPOSE:

Identifies the individual provider who directly rendered the service reported on the record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	12
FORMAT:	XXXXXXXXXXXX
RECORD LOCATION:	Columns 315 through 326
REQUIRED ON:	Medical Records when the service was provided by one of the following types of providers: • Physician or • Physician Assistant • Certified Pediatric or • Family Nurse Practioner • Certified Nurse Midwife or • Certified Physician's Assistant

COMMENTS:

Entries in this field are for specific types of individually identified providers only. Do not enter a group provider number or facility license number in this field. If any one of the above listed types of providers rendered the service, enter the individual provider's Medi-Cal provider number (preferred) or State license or certification number. When entering the appropriate provider, license or certification number, enter the individual's full number including alpha characters, using leading and trailing zeroes.

Left justify this field with trailing blanks.

If the reported service or procedure was provided by any type of provider not listed above, or the service or procedure was provided by an out-of-network provider, the options are to enter the individual's provider, license, or certification number or leave this field blank or fill with spaces.

43. DRUGS/MEDICAL SUPPLIES

PURPOSE:

Identifies the drug or whether a medical supply was dispensed.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	11
FORMAT:	XXXXXXXXXXX or 4 spaces/blanksXXXXXXX
RECORD LOCATION:	Columns 301 through 311
REQUIRED ON:	Pharmacy Records Only

COMMENTS:

When reporting the provision of a drug, enter the national drug code (NDC) assigned by the Federal Drug Administration (FDA).

If data element 44, Drug/Medical Supply Indicator is coded '2', indicating a medical supply was provided, this field can be filled with the following code: 9999MZZ. This seven byte alpha/numeric string must be preceded by four spaces or blanks and can be used to identify all medical supplies provided .

If a compound drug was provided, enter ten 9s and one 6 as in the following example:
99999999996

Embedded spaces are not allowed in this field.

The Uniform Product Codes (UPC) can be used in this data element.

Cross-reference this field with data element 44, Drug/Medical Supply Indicator.

44. DRUG/MEDICAL SUPPLY INDICATOR CODE

PURPOSE:

Identifies whether a prescription drug or medical supply was provided.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Columns 312
REQUIRED ON:	Pharmacy Records Only

COMMENTS:

Drug or Medical Supply Indicator Codes:

1 = Prescription Drug

2 = Medical Supply or over the counter drugs not requiring a prescription but supplied by the pharmacy.

If code 1 is entered in this field, then data element 43, Drugs/medical supplies, must have an eleven digit NDC number.

If code 2 is entered in this field, then data element 43, Drugs/Medical Supplies must have four spaces or blanks preceding 9999MZZ or an appropriate NDC number.

Cross-reference this field with data element 43, Drugs/Medical Supplies.

45. DRUG/MEDICAL SUPPLY QUANTITY

PURPOSE:

Identifies the quantity of drugs or medical supplies dispensed.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 313 through 317
REQUIRED ON:	Pharmacy Records Only

COMMENTS:

When reporting the quantity of drugs or medical supplies, the following guidelines are to be used:

Tablets, capsules, ampoules, diapers, injections, and most medical supplies - Report the total number of each item contained in the container. For example, when a cases of diapers are provided, report the total number of diapers not the number of cases. Or if a single bottle of 25 diabetic test strips was provided, report as 25, not 1. For injections sold as dry powders and reconstituted with water, report the number of injections the bottle will yield.

If the drug/supply is measured by weight (i.e., ointments, powders) report the number of grams rounding off to the nearest whole number.

For liquids, report the number of milliliters (ml). An exception here is for nutritional supplements which would be reported as the number of cans.

The value of this numeric field must be greater than zero and always a whole number. Do not use decimals.

This field is right justified with leading zeroes.

Cross-reference this field with data element 43, Drugs/Medical Supplies.

46. DAYS SUPPLY

PURPOSE:

Identifies the number of days covered by the prescription or medical supply.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	3
FORMAT:	XXX
RECORD LOCATION:	Columns 318 through 320
REQUIRED ON:	Pharmacy Records Only

COMMENTS:

The number entered for days supply must be greater than zero.

This field is right justified with leading zeroes.

Cross-reference with data element 43, Drugs/Medical Supplies

47. LONG TERM CARE (LTC) ACCOMMODATION CODES

PURPOSE:

Identifies type of accommodation for stays in long term care facilities.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	2
FORMAT:	XX
RECORD LOCATION:	LTC Records: Columns 301 through 302
REQUIRED ON:	Long Term Care Records Only

COMMENTS:

If the patient has been admitted to a nursing or intermediate care facility, enter the appropriate LTC accommodation code in this field.

See following page for Long Term Care Accommodation codes as updated May 2006.

(DE # 47 continued)

LONG TERM CARE (LTC) ACCOMMODATION CODES

NURSING FACILITIES (NF):	
NF-A (formerly Intermediate Care Facility {ICF})	
21	ICF REGULAR - INPATIENT
22	ICF REGULAR - LEAVE DAYS NON-DD PATIENT
23	ICF REGULAR - LEAVE DAYS - DEVELOPMENTALLY DISABLED
31	REHABILATATION PROGRAM-MENTALLY DISORDERED-INPATIENT
32	REHABILATATION PROGRAM-MENTALLY DISORDERED-LEAVE DAYS
39	BED HOLD FOR TRANSFER TO TRANSITIONAL INPATIENT CARE
NF-B (formerly Skilled Nursing Facility {SNF})	
01	NF REGULAR - INPATIENT
02	NF REGULAR - LEAVE DAYS NON-DD
03	NF REGULAR - LEAVE DAYS - DEV DISABLED
04	NF RURAL SWING BED PROGRAM - INPATIENT
05	NF RURAL SWING BED PROGRAM - LEAVE DAYS NON-DD
09	BED HOLD FOR TRANSFER TO TRANSITIONAL INPATIENT CARE
11	NF SPECIAL TREATMENT PROGRAM-MENTALLY DISORDERED-INPATIENT
12	NF SPECIAL TREATMENT PROGRAM-MENTALLY DISORDERED-LEAVE DAYS NON-DD
Transitional Inpatient Care:	
06	HOSPITAL-BASED - MEDICAL - REGULAR SERVICE
08	HOSPITAL-BASED - MEDICAL - LEAVE DAYS - non-DD patient
07	HOSPITAL-BASED - REHABILATIVE - REGULAR SERVICE
09	HOSPITAL-BASED - REHAVILATIVE - LEAVE DAYS - non-DD patient
24	FREESTANDING NF - MEDICAL - REGULAR SERVICE
26	FREESTANDING NF - MEDICAL - LEAVE DAYS - non-DD patient
25	FREESTANDING NF - REHABILATIVE - REGULAR SERVICE
26	FREESTANDING NF - REHAVILATIVE - LEAVE DAYS - non-DD patient
NF-B Adult Subacute:	
71	HOSPITALDP/NF-B - VENTILATOR DEPENDENT - INPATIENT
72	HOSPITAL DP/NF-B - NON-VENTILATOR DEPENDENT - INPATIENT
73	HOSPITALDP/NF-B - VENTILATOR DEPENDENT - BED HOLD
74	HOSPITALDP/NT-B - NON-VENTILATOR DEPENDENT - BED HOLD
75	FREESTANDING NF-B - VENTILATOR DEPENDENT
76	FREESTANDING NF-B - NON-VENTILATOR DEPENDENT

LONG TERM CARE (LTC) ACCOMMODATION CODES

NF-B Adult Subacute (Continued):	
77	FREESTANDING NF-B - VENTILATOR DEPENDENT - BED HOLD
78	FREESTANDING NF-B - NON-VENTILATOR DEPENDENT - BED HOLD
79	HOSPITAL DP/NF-B- VENTILATOR DEPENDENT - LEAVE DAYS
80	HOSPITALDP/NF-B - NON-VENTILATOR DEPENDENT - LEAVE DAYS
81	FREESTANDING NF-B - VENTILATOR DEPENDENT - LEAVE DAYS
82	FREESTANDING NF-B - NON-VENTILATOR DEPENDENT - LEAVE DAYS
Pediatric Subacute in Nursing Facilities-B:	
85	HOSPITAL DISTINCT-PART VENTILATOR DEPENDENT - REGULAR
86	HOSPITAL DP/NF-B NON-VENTILATOR DEPENDENT- REGULAR
87	HOSPITAL DP/NF-B VENTILATOR DEPENDENT - BED HOLD
88	HOSPITAL DP/NF-B NON-VENTILATOR DEPENDENT–BED HOLD
89	HOSPITAL D-P/NF-B VENTILATOR DEPENDENT - LEAVE DAYS
90	HOSPITAL DP/NF-B NON-VENTILATOR DEPENDENT – LEAVE DAYS
91	FREESTANDING NF-B- VENTILATOR DEPENDENT - REGULAR
92	FREESTANDING NF-B NON-VENTILATOR DEPENDENT - REGULAR
93	FREESTANDING NF-B VENTILATOR DEPENDENT - BED HOLD
94	FREESTANDING NF-B NON-VENTILATOR DEPENDENT - BED HOLD
95	FREESTANDING NF-B VENTILATOR DEPENDENT - LEAVE DAYS
96	FREESTANDINGNF-B NON-VENTILATOR DEPENDENT - LEAVE DAYS
Pediatric Subacute Rehab Support or Ventilation Weaning	
HOSPITAL-BASED - SUPPLEMENTAL REHABILITATION THERAPY SERVICE	
83	HOSPITAL DP/NF-B-SUPPLEMENTAL REHAB THERAPY SVCS-REGULAR
84	HOSPITALDP/NF-B - VENTILATOR WEANING SERVICE – REGULAR
97	FREESTANDING DP/NF-B - SUPPLEMENTAL REHABILITATION THERAPY SERVICE - REGULAR
98	FREESTANDING DP/NF-B - VENTILATOR WEANING SERVICE - REGULAR
Pediatric Subacute Codes listed above are only found with Vendor Code 83. Units of service reported with these codes do not represent inpatient days.	

(DE # 47 continued)

LONG TERM CARE (LTC) ACCOMMODATION CODES

INTERMEDIATE CARE FACILITIES (ICF):	
41	ICF DEVELOPMENTALLY DISABILITY PROGRAM (DD) - INPATIENT
43	ICF DEVELOPMENTALLY DISABILITY PROGRAM (DD)-LEAVE DAYS
45	ICF/DD 60-99 BEDS WITH 1-59 DISTINCT PART BEDS-INPATIENT
48	ICF/DD 60-99 BEDS WITH 1-59 DISTINCT PART BEDS-LEAVEDAYS
51	ICF/DD 100 OR MORE BEDS WITH 60-99 DISTINCT PART BEDS – INPATIENT
52	ICF/DD 100 OR MORE BEDS WITH 60-99 DISTINCT PART BEDS – LEAVE DAYS
61	ICF/DD HABILITATIVE (DDH) (4-6 BEDS) - INPATIENT
62	ICF/DD-NURSING (DDN)(4-6 BEDS) - INPATIENT
63	ICF/DD HABILITATIVE (DDH) (4-6 BEDS) - LEAVE DAYS
64	ICF/DD-NURSING (DDN) (4-6 BEDS) - LEAVE DAYS
65	ICF/DD-HABILITATIVE (DDH) (7-15 BEDS) - INPATIENT
66	ICF/DD-NURSING (DDN) (7-15 BEDS) - INPATIENT
68	ICF/DD-HABILITATIVE (DDH) (7-15 BEDS) - LEAVE DAYS
69	ICF/DD-NURSING (DDN) (7-15 BEDS) - LEAVE DAYS
ICF/DD-CN PILOT PROGRAM	
55	ICF/DD-CN VENTILATOR DEPENDENT – REGULAR
56	ICF/DD-CN NON-VENTILATOR DEPENDENT – REGULAR
57	ICF/DD-CN VENTILATOR DEPENDENT – LEAVE DAYS DD PATIENT
58	ICF/DD-CN NON-VENTILATOR DEPENDENT

48. DAYS STAY

PURPOSE:

Indicates the patient's number of days stay in a hospital or long-term care (LTC) facility.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	3
FORMAT:	XXX
RECORD LOCATION:	Hospital Records: Columns 354 through 356 LTC Records: Columns 303 through 305
REQUIRED ON:	Hospital Records Long Term Care Records

COMMENTS:

This field captures the patient's length of stay in a hospital or long-term care facility. The discharge day is not counted unless the patient was admitted and discharged on the same day. The discharge day is counted if the patient expired in the hospital. For example, if a patient was admitted on October 23, 1995 and was discharged alive on October 31, 1995, the day's stay for this record would be entered as 008. If the same patient dies instead of being discharged alive on October 31, the day's stay would be entered as 009.

If a patient was still in the hospital when submitting the record to the state, indicate the number of days stay between the patient's admit date and the last date of service as reported on the record. Instead of entering a discharge date in data element 50, zero fill the discharge date field. Indicate on the record all relevant header information including the beginning and ending dates of service, data elements 19 and 20. Also, enter the patient's status as still admitted (code 30 or 31) in data element 51, patient status.

This field is right justified with leading zeroes and must be greater than zero.

49. ADMISSION DATE

PURPOSE:

Identifies the patient's date of admission to an acute care hospital or long-term care facility.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Hospital Records: Columns 314 through 321 Long Term Care Records: Columns 308 through 315
REQUIRED ON:	Hospital Records Long Term Care Records

COMMENTS:

Enter the date the patient was admitted to either a hospital or LTC facility (i.e., nursing or intermediate care facility). The admission date must always be the same as or earlier than the date of discharge.

Example: If the patient's admission date was October 24, 2005, it would be entered as 20051024.

Do not use special characters such as slashes, commas or hyphens.

Cross reference with data element 50, Discharge Date.

50. DISCHARGE DATE

PURPOSE:

Identifies the patient's date of discharge from a hospital or long-term care facility.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Hospital Records: Columns 322 through 329 LTC Records: Columns 316 through 323
REQUIRED ON:	Hospital Records Long Term Care Records

COMMENTS:

Enter the date the patient was discharged from either a hospital or LTC facility (i.e., nursing or intermediate care facility). The discharge date must always be the same as or later than the date of admission.

If the patient has not been discharged at the time the record is reported to the state, zero fill this field. If the patient is on a leave status or bed hold enter the date this change took place and the date the patient returned or was discharged. For patient status codes (DE 51) 06, 07, 08 and 09 the date range must be used.
The day of discharge is excluded from the days stay (Data Element 46) calculation except when it is the same date as the date of admission or the patient expires in the hospital, in which case the discharge day would be counted.

Do not enter any future or expected dates of discharge.

Do not use special characters such as slashes, commas or hyphens.

Example: November 22, 2005 would be entered as 20051122.

Cross-reference with data element 49, Admission Date.

51. PATIENT STATUS CODE

PURPOSE:

Indicates patient's inpatient or outpatient status as of the ending date of service reported on this record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	2
FORMAT:	XX
RECORD LOCATION:	Medical Records: Columns 327 through 328 Hospital Records: Columns 302 through 303 LTC Records: Columns 306 through 307
REQUIRED ON:	Hospital Records Long Term Care Records Medical Outpatient Records when applicable (see next page)

COMMENTS:

Each hospital inpatient record must indicate the patient's status by entering one of the numeric UB92 valid values listed below. .

HOSPITAL INPATIENT DISCHARGE/STATUS CODES:
01 = Discharged to home or self care 02 = Discharged/transferred to another acute care hospital 03 = Discharged/transferred to a SNF 04 = Discharged/transferred to an ICF 05 = Discharged/ transferred to another type of facility not Not defined in code list 06 = Discharged/transferred to home under HHA before Admit to SNF 07 = Left against medical advice or discontinued care 20 = Expired 30 = Still patient or expected to return

(DE # 51 Continued)

For Hospice records enter one of of the following UB-92 codes:

40 = Expired at home 41 = Expired in a hospital, SNF, ICF or freestanding hospice 42 = Expired, place unknown

For long term care records, enter one of the following numeric discharge/patient status codes:

LONG TERM CARE DISCHARGE/PATIENT STATUS CODES
00 = Still under care 01 = Admitted (interim bill) 02 = Expired (Deceased) 03 = Discharged to acute hospital 04 = Discharged to home 05 = Discharged to another Long Term Care facility 06 = Leave of absence to acute hospital (bed hold) 07 = Leave of absence to home 08 = Leave of absence to acute hospital/discharged 09 = Leave of absence to home/discharged 10 = Admit/expired 11 = Admitted/discharged to acute hospital 12 = Admitted/discharged to home 13 = Admitted/discharged to another long term care facility 32 = Transferred to TC status in same facility

Codes to be used by hospitals, SNFs, HHAs, and

43 = Discharge/transferred to a federal health care facility 50 = Discharge to hospice-home 51 = Discharge to hospice-medical facility 61 = Discharge/transferred w/in facility to swing bed 62 = Discharge/transferred to inpatient rehab facility or rehab distinct part unit 63 = Discharged/transferred to Medicare long term care hospital 64 = Discharged/transferred to Medicaid long term care facility 65 = Discharged/transferred to a psych hospital or distinct part of a hospital

(DE # 51 Continued)

For medical outpatient records (code M in data element 3), enter one of the applicable alphabetic codes listed below. If none of the medical outpatient codes are applicable to this record, leave this field blank or fill with spaces.

MEDICAL OUTPATIENT STATUS CODES
AA - Referred to Another Physician
AB - Return to Referring Physician
AC - Return if Needed – PRN
AD - Telephone Follow Up
BA - Referred to CHDP
BB - Referred to CCS
BC - Referred for CPSP Services
BD - Referred for WIC Services

52. ADMISSION NECESSITY CODE

PURPOSE:

Identifies the type or reason for the patient's admission into an acute care hospital.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 301
REQUIRED ON:	Hospital Records

COMMENTS:

For service date on and subsequent to January 1, 1996 enter one of the following numeric codes indicating the necessity or reason for admitting the patient into the hospital. "4" is to be used for delivery. If the newborn remains an inpatient when mother is discharged "3" is to be used to identify the newborns' inpatient stay.

HOSPITAL ADMISSION NECESSITY CODES:

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5 = Trama Center
9 = Information Not Available

53. PRIMARY SURGICAL PROCEDURE CODE

PURPOSE:

Identifies primary surgical procedure performed during hospital inpatient stay.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 304 through 308
REQUIRED ON:	Hospital Records

COMMENTS:

Enter appropriate CPT- 4 or ICD-9 surgical code identifying the primary surgical procedure. If no surgery has been performed, leave this field blank or fill with spaces.

The code should be left justified with trailing blanks. Trailing zeros will result in an error.

54. SECONDARY SURGICAL PROCEDURE CODE

PURPOSE:

Identifies secondary surgical procedure performed during hospital inpatient stay.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 309 through 313
REQUIRED ON:	Hospital Records

COMMENTS:

Enter appropriate CPT- 4 or ICD-9 surgical code identifying the primary surgical procedure. If no surgery has been performed, leave this field blank or fill with spaces.

The code should be left justified with trailing blanks. Trailing zeros will result in error.

55. DATA ELEMENT

FILLER – NOT USED AT THIS TIME IN CAPTITATED PROGRAMS

56. NUMBER OF CLAIM LINES

PURPOSE:

Identifies the number of completed hospital claim line (detail segments) appended to the header segment of each hospital inpatient record.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	2
FORMAT:	XX
RECORD LOCATION:	Columns 349 through 350
REQUIRED ON:	Hospital Records

COMMENTS:

For each hospital record, there can be up to 22 claim lines or detail segments. Each segment contains several fields, described elsewhere in this manual, including the accommodation/ancillary codes, indicating the type of hospital room or accommodation (i.e., room & board, semi-private, 2 bed pediatric) and types of services and supplies provided and charged directly by the hospital. Each segment also includes the number of days stay, amount billed and reimbursed amount.

For each hospital record, there must be at least one detail and no more than 22 detail segments completed. The number of segments completed for each hospital record must correspond with the number (01 - 22) entered in this data element, number of claim lines.

If more than 22 detail segments need to be entered, start a new record including a new, unique Claim Reference Number in Data Element 1.

57. ACCOMMODATION and ANCILLARY CODES

PURPOSE:

Identifies the type of accommodation and/or ancillary service(s) provided by the hospital.

FIELD DESCRIPTION:	
CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	3
FORMAT:	XXX
RECORD LOCATION:	Columns 351 through 353
REQUIRED ON:	Hospital Records

COMMENTS:

Enter UB92 accommodation and/or UB92 ancillary codes in this field. A minimum of one accommodation or ancillary code is required to be entered in this field for each hospital record. A maximum of 22 accommodation/ancillary codes can be entered for each record. If the number of detail segments is insufficient for the record, (i.e., greater than 22), start a new record beginning with a unique claim reference number in Data Element 1.

If less than 22 detail segments are filled, leave the remaining detail segments blank. Do not space fill the remaining, unused detail segments.

Cross-reference with data element 56, number of claim lines.

APPENDIX A

Standard Code Sets Used

STANDARD CODE SETS USED

PROCEDURE & RELATED MODIFIER CODES

The combination of CPT-4 and HCPCS are the code sets used for physician services and other health care services:

CPT-4

Common Procedure Coding Service (HCPCS) Level I, is the same as the Current Procedural Terminology (CPT) 4th edition, used to code physician services (including maxillofacial surgery). The American Medical Association owns and maintains CPT-4 except for anesthesia codes. The use of the specific data elements, including codes and modifiers, is enumerated in the HIPAA implementation specifications.

HCPCS Level II

Procedure and modifier codes are used to report other health related services (ancillary services, radiology and laboratory, other medical diagnostic procedures, physical and occupational therapy, hearing and vision services and medical transportation), other substances, equipment, supplies, or other items used in health care services includes medical supplies, orthotic and prosthetic devices, and durable medical equipment. Level II HCPCS is maintained and distributed by the U.S. Department of Health and Human Services.

HCPCS Level III

Are procedure codes that have been developed by individual states for their own programs. With the implementation of HIPAA, use of HCPC Level III codes will no longer be allowed, on a routine basis. There have been a limited number of modifiers identified for specific use and designation by individual states.

National Drug Codes (NDC)

For pharmaceuticals (drugs and biologics). The NDC codes are maintained and distributed by the U.S. Department of Health and Human Services, in collaboration with drug manufacturers. The specific data elements for which the NDC is a required code set are enumerated in the HIPAA implementation specifications.
http://www.fda.gov/cder/ndc/index.htm

UB-92

Also called the CMS-1450, was developed and approved for use in 1992. Hospitals, skilled nursing facilities (SNF) and other providers such as home health practitioners utilize the UB-92 to bill Medicare. Other major third party payers (Medicaid, Blue Cross/Blue Shield, commercial insurers and managed care plans) have substantially adoped Medicare UB-92 guidelines. The UB-92 is not used for billing the professional component.

DIAGNOSIS CODES

ICD-9-CM

International Classification of Diseases, Ninth Edition Volumes 1 and 2, are used for the descriptor of diseases, injuries, impairments, other health related problems, their manifestations, and causes of injury, disease, impairment, or other health related problems. This code set is maintained and distributed by the U.S. Department of Health and Human Services.

DISCHARGE/PATIENT STATUS CODES

Discharge status/patient status codes are used by hospitals, long term care facilities, hospice and home health agencies. Patient status codes are found in the UB-92 coding manuals.

PLACE OF SERVICE CODES

Medical and Professional Claims

Maintained by the Department of Health & Human Services/Centers for Medicare &Medicaid Services (CMS) is listed in Chapter 26 in the Medicare/Medicaid manual. http://www.cms.hhs.gov/manuals/

Inpatient and Long Term Care

First two digits of the Facility Type coding found in the UB-92 coding manuals is used as the place of service code..

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APPENDIX B

APPENDIX B

LIST OF ABBREVIATIONS

This is a list of abbreviations referenced in this document.

ASCII	American Standard Code for Information Interchange
BID	Medi-Cal Beneficiary Identification
CMC	Computer Media Claim
CRN	Claim Reference Number
DSB	DHS Data Systems Branch
EBCDIC	Extended Binary Coded Decimal Interchange Code
GMC	Geographic Managed Care
HWDC	Health and Welfare Data Center
LTC	Long Term Care
MMCD	Medi-Cal Managed Care Division
MCP	Managed Care Plan
NDC	National Drug Code
PCP	Primary Care Physician
SSN	Social Security Number
UPC	Uniform Product Code